REFUGEE HEALTH PROVIDERS MANUAL

REFUGEE HEALTH PROGRAM
OFFICE OF MINORITY HEALTH
RHODE ISLAND DEPARTMENT OF HEALTH

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Contents

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Last but not least, the Refugee Health Program thanks the refugees who have resettled in Rhode Island and continue to enrich our communities and health systems.

Thank you all.

Preface

Welcome to the Rhode Island Refugee Health Program Providers' Manual. This manual is a resource for health care and social service providers who serve refugees. It describes in detail the process of refugee resettlement, expectations for the refugee health screening, and cultural profiles describing some of the refugee groups being resettled in Rhode Island.

It is the intention of the Refugee Health Program to continue to provide up-to-date information to providers. Consequently, the office will periodically produce additional chapters for the manual that can be downloaded from the website (www.health.ri.gov) or mailed to you.

We hope this initiative will be useful to you. We welcome any comments you may have. For comments, suggestions or questions, please contact Maria-Luisa Vallejo, Refugee Health Coordinator at 401-222-7638 or MariaLuisa.Vallejo@health.ri.gov.

I

OVERVIEW OF REFUGEE RESETTLEMENT

I-A: Overview: Rhode Island Refugee Health Program

The Office of Minority Health at the Rhode Island Department of Health (HEALTH) formally initiated a Refugee Health Program (RHP) in August of 2004. The goal of the program is to ensure that refugees and asylees enter into a comprehensive system of care that adequately responds to their unique health care needs by addressing three main components:

- Coordination of care
- Education and training
- Surveillance and epidemiology

The Refugee Health Program works with refugee resettlement agencies, state programs, and medical and social service providers to develop coordinated and comprehensive health services for refugees. The Refugee Health Program also provides training specifically for medical providers who work with refugees and maintains a database to track refugee health information for planning and reporting functions.

The Department of Human Services (DHS) is the state agency responsible for refugee resettlement. The State Coordinator of Refugee Resettlement at DHS manages contracts for refugee reception and placement, employment assistance, English as a second language instruction and case management. The refugee resettlement agencies (a.k.a. VOLAGS) and Rhode Island College are contracted by DHS to deliver these services.

The Refugee Health Program at the Rhode Island Department of Health collaborates with the DHS and the contracted agencies to ensure comprehensive, quality, and appropriate health services.

I-B: Immigrant Statuses Eligible for Refugee Services

Refugee status is determined by the Department of Homeland Security before a person is eligible for resettlement in the United States. Refugees are a category of immigrants who arrive with legal resident status in the United States and as such are entitled to all of the rights and responsibilities of legal residents.

Per the Immigration and Nationality Act, refugees, including Cuban/Haitian entrants and certain Amerasians, are eligible for refugee health services for a period of eight months from the date they entered the United States. Asylees and victims of severe forms of trafficking are also eligible to receive refugee health assessment. Throughout this manual, the term "refugee" will be used to refer to all populations eligible for refugee services as defined below.

- **Refugee**
  Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.[1]

- **Asylee**
  An individual who has received permission to remain in the United States, under Section 208 of the Immigration and Nationality Act (INA), based on a "well founded fear of persecution" should the alien return to their native land. A prospective asylee applies for this permission from United States soil, unlike a refugee who applies from abroad. Asylees of all nationalities are eligible for Refugee Health Assessment Program services within 90 days of U.S. entry. With the exception of certain Cuban and Haitian entrants, asylum applicants are not eligible for services.

- **Cuban/Haitian Entrant**
  (a) Any individual granted parole status as a Cuban/Haitian Entrant (Status Pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; and (b) Any other national of Cuba or Haiti
    (1) Who:
      (i) Was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act;
      (ii) Is the subject of exclusion or deportation proceedings under the Immigration and Nationality Act; or
      (iii) Has an application for asylum pending with the Immigration and Naturalization Service; and
    (2) With respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered.[2]

- **Certain Amerasians**
  Persons from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, are also eligible to receive ORR assistance and services.
  This definition is contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Pub. L. No. 100-461 as amended).

- **Severe forms of trafficking in persons**
  (A) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or (B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

The Office of Refugee Resettlement (ORR) also assists individuals who have permanent resident status in the United States, provided that these individuals held one of the above-mentioned statuses before becoming permanent residents (i.e. “green card” holders).

I-C: Refugee Arrivals

In the 26 years since the Refugee Act of 1980, more than 4300 refugees have been resettled in Rhode Island. Each year, the number of refugee arrivals fluctuates based on the stability in refugees' countries of origin, international affairs, and United States political policies. The President of the United States must re-authorize the Refugee Resettlement Program every year and then determine the cap or limit on the number of refugees who will be admitted to the U.S.

The fluctuation in the number of refugees Rhode Island has received in recent years is reflected in Appendix A. In federal fiscal year 2007 (FY 2007), Rhode Island expects to receive approximately 300 refugees. The lowest number of refugees received (84) occurred during FY 2002. This number partially reflects the September 11, 2001 attack and subsequent changes to U.S. immigration policies. (See Appendix A)

I-D: Durable Solutions for Refugees

Refugees resettled in Rhode Island have already endured several prerequisite determinations. First, the person must qualify as a refugee under the 1967 United Nations Protocol relating to the Status of Refugees and the United States' Refugee Act of 1980 (see definitions in I-B). Once refugee status has been established, the United Nations, working in concert with the International Organization on Migration and country governments, will exercise one of the three long-term solutions for refugees:

- **Repatriation**
  Repatriation is the preferred option in which the refugee voluntary returns to his/her country of origin

- **Integration**
  Integration into the host country is the second option in which the country hosting the refugee legally recognizes and admits the person as an immigrant

- **Third country resettlement**
  Third country resettlement is the last option for refugees. Third country resettlement requires another country to accept the refugee with the knowledge that the placement is permanent; the refugee cannot return to his/her country of origin.

I-E: Overseas Medical Examinations and Travel to the United States

All refugees approved for third country resettlement undergo an overseas medical examination, also referred to as a pre-departure screening, before traveling to their new home. Overseas examinations are conducted to ensure that refugees do not have identifiable excludable conditions that would prevent them from entering the United States. Overseas medical examinations are done by a local panel of physicians, or by physicians working under contract to the International Organization for Migration, and uses locally available facilities (laboratory, x-rays). The Division of Global Migration and Quarantine, Centers for Disease Control and Prevention (CDC), is responsible for oversight of all overseas examinations.

The existence of certain medical conditions are, including certain communicable diseases and mental health conditions associated with violence, are grounds for exclusion from entry into the United States. (Appendix B) Refugees with communicable diseases that preclude their entry into the country may be delayed until appropriate treatment is initiated and they are no longer infectious. Refugees with other excludable conditions may apply for a waiver for admissibility.

I-F: Overseas / Pre-Departure Screening

- For all ages: Physical Exam and documentation of findings
- For persons ≥15 years: Chest X-ray to assess TB, test for HIV, syphilis and other sexually transmitted infections
- According to the CDC, the following conditions can exclude an individual from entering the USA, unless the disease is treated, a waiver is issued by Bureau of Citizenship and Immigration Services, or both.
  - — Active TB
  - — HIV infection
  - — STD's (syphilis, gonorrhea, lymphogranuloma venereum, chancroid)
  - — Leprosy
  - — Severe physical or mental disability

If approved for travel, refugees enter the U.S. at one of eighteen ports of entry that operate quarantine stations staffed by quarantine inspectors from the CDC. The current quarantine stations are in Anchorage, AK; Atlanta, GA; Boston, MA; Chicago, IL; Detroit, MI; El Paso, TX; Honolulu, HI; Houston, TX; Los Angeles, CA; Miami, FL; Minneapolis, MN; Newark, NJ; New York, NY; San Diego, CA; San Francisco, CA; San Juan, PR; Seattle, WA; and Washington, DC. According to the CDC website (http://www.cdc.gov/ncidod/dq/quarantine_stations.htm),

> *"These field stations will provide advanced emergency response capabilities, including isolation and communications facilities. Regional health officers assigned to each station will provide clinical, epidemiologic, and programmatic support, and quarantine public health officers will conduct surveillance and response and communicable disease prevention activities."*

Once cleared by quarantine inspectors, notification including the overseas exam results is sent to the Refugee Health Program in Rhode Island for each refugee being resettled in Rhode Island. (See Appendix C)

References:

1. Centers for Disease Control Technical Instructions for Panel Physicians: http://www.cdc.gov/ncidod/dq/panel.htm
2. Immigration & Nationality Act - [INA § 101(a)(42)(a); 8 USC § 1101(a)(42)(a)]
3. Refugee Education Assistance Act of 1980, Pub. L. No. 96-422

II

RHODE ISLAND REFUGEE HEALTH SCREENING PROCESS

II-A: Refugee Health Screening Process

The U.S. Department of State requires that refugees receive a health screening within 30 days of arrival in the U.S. or within 7 days of arrival for HIV positive refugees. The purpose of the domestic health screening is to verify the overseas screening results and identify any health condition that poses a threat to the individual's or public's health. Furthermore, the domestic health screening facilitates entry into the primary care system, and informs the refugee surveillance system operated by the Refugee Health Program (See Appendix D).

The Rhode Island Refugee Health Screening Form delineates the minimum standard for an initial health assessment of refugees resettled in Rhode Island. The screening form also promotes uniformity of services across institutions. Following the initial screening, refugees should be accepted into ongoing primary care at that screening site or referred to another provider for primary care. In addition, the Rhode Island Refugee Health Screening Form is a tool for screening providers to use in making other health referrals as needed.

Under federal legislation, refugees are eligible for eight months of medical coverage from their date of entry into the country. The medical coverage is administered through the state Medicaid program in the state in which they settled, or paid by Refugee Medical Assistance (federal funding for health services for refugees). In Rhode Island, refugees are enrolled in either RIte Care or Medical Assistance for the eight-month period. The refugee health screening is a covered expense under these programs. After the guaranteed coverage expires, refugees may continue to receive state health benefits if they meet the eligibility requirements put forth by the Department of Human Services.

II-B: Refugee Health Screening Form

Refugees should receive a health screening within 30 days of arrival (within 7 days for HIV+ refugees). Some refugees arrive with Class B conditions that require rapid follow-up. If this is the case, there will be a notation on the refugee's overseas medical record indicating the follow-up needed and how quickly it should be provided. The refugee should bring a copy of his/her overseas exam results to the initial health screening in the United States. In Rhode Island, VOLAGS coordinate with screening sites to schedule appointments. Following the screening, a completed R.I. Refugee Health Screening Form (Appendix E) should be mailed or faxed to the Refugee Health Program at the Department of Health within an additional 30 days. Results from any additional screenings or tests ordered by the provider should not be forwarded to the Refugee Health Program.

Currently, partial or complete refugee medical screenings are performed at Rhode Island Hospital, including Hasbro Children's Hospital; The Miriam Hospital; Women and Infants Hospital; St. Joseph's Hospital; and the Providence Community Health Centers. The medical provider who performs the health assessment completes the tri-part form. The white copy of the form should be faxed or mailed to the Refugee Health Program within 30 days of completion. The fax number and address is listed at the top of the form. The yellow copy of the form goes in the patient's medical record and the pink copy should be provided to the patient. Medical providers can obtain additional screening forms by contacting the Refugee Health Program at 401-222-2901. See Appendix F for a listing of public health, medical and social service practitioners providing services to refugees.

R.I. Refugee Health Screening Form Uses

- Verify overseas exam results
- Identify individual and public health threats
- Establish minimum screening components
- Promote uniform care
- Facilitate entry of refugee into the primary care system
- Surveillance

Periodically, health advisories or screening recommendations are issued by the Centers for Disease Control and Prevention (CDC) or the Office of Refugee Resettlement (ORR). In such an event, the Refugee Health Program will publicize the information to providers and post it on the Health Department website (www.health.ri.gov).

Since 2004, the CDC has issued revised Lead Screening Guidelines for Refugee Children, Presumptive Treatment Recommendations for Somali Bantu, and Presumptive Treatment Recommendations for Sudanese refugees. Refugee health providers, including residents and clinic staff, are expected to implement all screening and treatment recommendations endorsed by the Department of Health.

II-C: Refugee Health Partners

The Refugee Health Program works with refugee resettlement agencies, state programs, and medical and social service providers to develop coordinated and comprehensive health services for refugees. The Refugee Health Program also provides training for medical providers who work with refugees and maintains a database to track refugee health information for planning and reporting functions. Providers may call the Refugee Health Program at (401) 222-2901 or fax (401) 222-4392 to schedule a training.

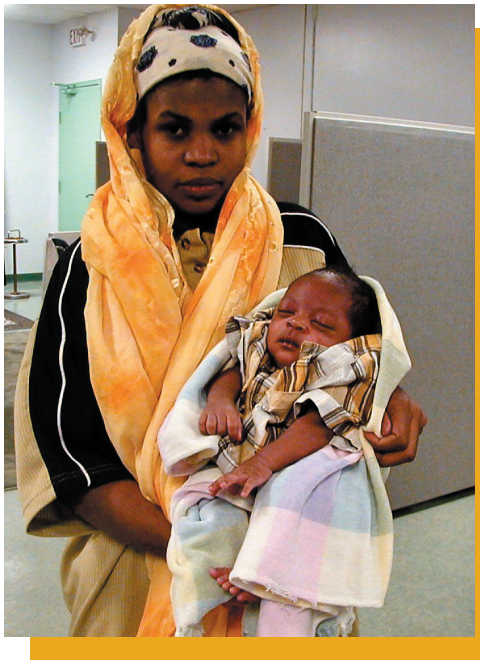
The Refugee Health Committee, a network of professionals who provide direct services to refugees or are otherwise involved in refugee health services, acts in an advisory role to the Refugee Health Program. Membership includes representation from the two Rhode Island refugee resettlement agencies, Department of Health programs, the Department of Human Services, refugee health screening sites, hospital administrators, mental health and nursing professionals, and social service providers. The committee meets quarterly and is chaired by the Refugee Health Coordinator.

III

GENERAL CULTURAL CONSIDERATIONS FOR REFUGEES

Today the health care system is challenged by the rapid growth of a multicultural society. Service providers need to be sensitive to the possible differences and subsequent incongruence of perceptions with those they serve. They also need to be cognizant that there are differences among and within the cultures they serve.

Overall, doctors, nurses and providers should keep in mind that they will be confronted with very different cultures but also realize that there are more similarities than differences. Believing many people "see the world differently" and conceptualizing health and healing practices in many other ways will help practitioners to understand the cultural boundaries of refugees. For example: the involvement of spirits, such as the "evil eye" believed to attract evil spirits to an infant or child, is thought to be a cause of illness in certain cultures. These and other traditional customs should be respected.



III-A: Preparation for Consultation

Many people from refugee backgrounds will not have had access to comprehensive health care for years, if ever. Their initial contact with US health care providers may be the first opportunity in their lives to receive client-focused, high quality health care. At the same time, building a relationship and providing optimal care to refugees can be a challenge for health professionals. Refugees often lack knowledge of English, leading to feelings of isolation and mistrust. The health system will often seem very complicated to refugees and they may need assistance with acquiring prescriptions and other tasks. Many may be suffering from serious mental illnesses due to trauma and grief and may be stigmatized by their society. There may be shame associated with certain contracted diseases such as HIV. Additionally, women may often prefer a female practitioner and may experience strong emotional and psychological responses during gynecological exams due to past sexual abuse.[1]

III-B: Health Beliefs and Practices

Body modification
Virtually all cultures engage in some sort of body modification, such as tattooing or piercing. The reasons for this are complex and may relate to personal enhancement, hygiene, rites of passage, traditional healing and other sociological reasons. Some of these practices are temporary, such as henna paintings on the extremities, which are considered by some Middle Eastern groups to have healing properties. Other procedures such as scarification are permanent and may involve procedures such as cutting, burning or piercing. While most of these procedures are harmless, some are not, or may be mistaken for serious pathology.

Body modification procedures may include:

- "Coin Rubbing" among Southeast Asian cultures – traditional healing where the edge of a coin is rubbed over the skin producing a red stripe. (Sometimes this practice may be mistaken for child abuse.)
- Artificial penile nodules in Southeast Asian men – foreign bodies are implanted under the skin of the penis to enhance sexual performance.
- Scars or lesions, especially in African cultures – found on the trunk of face, and other parts of the body; the cutting or burning procedures producing the scars or lesions may be done for ritual reasons, body enhancement, or for traditional healing.
- Male circumcision, particularly among Muslim males.
- Amputation of the uvula in some African groups – a traditional healing practice.
- Female genital cutting (FGC), also called female circumcision or female genital mutilation (FGM). Common in parts of Africa, the Middle East, and Asia, FGC/FGM is illegal in the United States.

All groups may delay medical treatment because they will first resort to traditional diagnosis (either herbal or spiritual). This may cause a serious delay resulting in disease or death. Thus, they may seek medical care late in an illness. It has been observed by refugee camp aid workers that mothers do not seek medical care in good time, bringing their children in when they are already at a critical stage. There may also be problems of adherence to treatment regimes that require long-term sustained used of medicine.

Doctors should stress the importance of regular check-ups for pregnant mothers and children (especially well-baby check-ups). Providers as well as nurses will be required to explain the significance of "prevention" since refugees may not be familiar with this concept.

III-C: Trauma among Refugees

Most refugees arriving in this country will have been exposed to traumatic events. These may include:

- The experience of being transplanted from their country of origin to a highly industrialized country
- Threats to their own lives or those of their family or friends
- Witnessing death squad killings, mass murder and other cruelties inflicted on family and friends
- Disappearances of and separation from family members or friends
- Perilous flight or escape with no personal protection
- Forced marches
- Extreme deprivation – poverty, unsanitary conditions, hunger, lack of health care
- Persistent and long-term political repression, deprivation of human rights and harassment
- Removal of shelter or forced displacement from homes
- Refugee camp experiences involving prolonged squalor, malnutrition, physical, psychological and sexual abuse, absence of personal space, and lack of safety

III-D: Relocation Stress

Studies have shown that the first year after their arrival in the United States is the period of greatest psychological strain for refugees. It is very important that families have strong social support as well as instruction since they are entering into a complete lifestyle change. Major psychosocial issues in resettlement are:

- Housing: Housing in countries of second asylum is usually very different from the refugee's place of origin. They may not be used to having hot and cold water, and flush toilets, hence they may need instructions on related safety issues.

- Transportation: A major reason for noncompliance with health care for refugees is lack of transportation to the clinics.

- Language: Difficulty learning a new language creates a great deal of the stress associated with relocation. Most communities offer ESL (English as a Second Language) classes. However learning a new culture, means of livelihood, and all the other new experiences make learning the language very difficult for many. Older people, in particular, have great difficulty surpassing language barriers.

- Customs and protocols: Everything in the host country is new, from obtaining food and registering for school, to childbirth and money matters. The issue of medical insurance or benefits is foreign to refugees in the U.S.

- Technology: Items we take for granted, such as washing machines, televisions, VCR's, telephones, microwaves, and computers are rare in the refugees' countries of origin.

References:

1. Refugee Health Care: A Handbook for Health Professionals, The Consultation – Communicating Effectively with Refugee Clients, Minister of Health, New Zealand, November 2001

IV

COMMON HEALTH CONSIDERATIONS FOR REFUGEES

Due to their experiences prior to resettlement and during the resettlement process, refugees often require comprehensive medical services upon arrival, including:

- Immunizations
- Treatment for Infectious Diseases
- HIV/AIDS Care
- Oral Health Care
- Mental Health Services
- Treatment for diseases and conditions related to social, environmental and behavioral factors

Reliable health data are limited and complete medical histories are scarce among the incoming populations. Awareness of their situation can help eliminate disparities in the health statuses of refugees in the U.S.

IV-A: Immunizations

Many refugees may have incomplete immunization/vaccination records. Immunization for all refugees is a priority. The immunization status of children of refugees is based on serology and records if available. At the initial refugee health screening, providers should review the vaccination record of the refugee and begin administering any catch-up vaccinations. Providers should administer the recommended child or adult vaccination schedule as determined annually by the Advisory Committee on Immunization Practices (ACIP) and distributed by the CDC (http://www.cdc.gov/nip/).

Refugees who do not have documentation of vaccinations should be considered unvaccinated and should either be tested for immunity or be vaccinated.

Because of recent outbreaks of vaccine-preventable diseases among United States bound refugees and to avoid costly delays in resettlement, CDC is also recommending that refugees receive the following age-appropriate vaccines before they enter the US: diphtheria and tetanus toxoids and pertussis (DTP) vaccine, tetanus and diphtheria toxoids (Td), oral polio vaccine (OPV), measles-mumps-rubella (MMR) vaccine, hepatitis B vaccine, and varicella vaccine. (Letter from CDC's Division of Global Migration and Quarantine dated June 23, 2004.)

Live virus vaccines can temporarily suppress tuberculin reactivity. If a tuberculin skin test is indicated and cannot be performed at the same time that the live virus vaccine is given, the tuberculin skin test should be deferred for 4-6 weeks.

IV-B: Infectious and Parasitic Diseases

Infectious and parasitic diseases are common in many of the countries of origin of refugees. While refugees will have been screened for a number of these diseases, it is well known that relapses can occur and chronic disease is debilitating. For example, Plasmodium Malaria (PM) infections not only produce typical malaria symptoms but can persist in the blood for decades. A person with asymptomatic PM, however, can infect others. When examining refugees consider the following:

- TB infection and disease should always be considered in refugee groups.
- Sexually transmitted infections (STIs) are increasingly common and testing should be carried out in a sensitive manner with informed consent and appropriate counseling.
- Some helminthes infections (strongyloides, opisthorchis, schistosomiasis) may be asymptomatic and persist for many years before causing serious disease.
- Somali Bantu and Sudanese refugees should be presumptively treated for Schistosomiasis and Strongyloidiasis
- Refugees with hepatitis B or hepatitis C should be managed according to protocols.

Some common communicable diseases encountered among refugee populations are listed as following:

- **Hepatitis B**
  In Southeast Asia, the hepatitis B virus (HBV) is hyperendemic.[1] Although the exact prevalence of hepatitis B is not known, research has shown that, for example, the Burmese population typically has about 15% rates of chronic hepatitis B infection. Having chronic hepatitis B increases the chance of permanent liver damage. Perinatal transmission is common. Typically only pregnant women are tested for or vaccinated against hepatitis B before resettlement. Nonetheless, two hepatitis outbreaks in refugee camps have been associated with the scarcity of water and its impact on personal hygiene. A similar outbreak in a refugee camp in Somalia was attributed to enterically transmitted, non-A, non-B viral hepatitis (hepatitis E).[2]

- **Tuberculosis**
  Little public information exists on the burden of disease and appropriate intervention strategies for the prevention and treatment of tuberculosis among refugees. International organizations are presently working to expand the assistance plan specifically to settings with high HIV prevalence and with high Multi Drug Resistant-TB prevalence. Furthermore the plan calls for monitoring and surveillance of tuberculosis epidemiological situations and trends, drug resistance and program performance.

- **Malaria**
  The refugees coming from Mae Sot on the Thai-Burma border region as well as those from Africa are at high risk for malaria, in particular multi-drug resistant strains. The majority of malaria deaths occur in Africa and among non-immune individuals in areas where appropriate treatment is not available. In many cases, drug resistance is increasing. The rapid adaptation of the virus to anti-malarial drugs is making malaria increasingly complex to treat. Malaria incidence can also be particularly high among refugees who have settled in an area of higher transmission than their region of origin and who, therefore, are not immune.

- **Measles**
  Measles ranks as one of the leading causes of children's deaths worldwide and it is still prevalent in developing countries. It is a very contagious disease and is associated with high mortality, severe complications, and vulnerability to other infections. In developing countries, children under 5 represent the highest proportion of cases. Up to 25 percent of the cases are children under 9 months. Measles is the leading cause of mortality among refugee children. Initial immunization is standard procedure in any refugee situation.

IV-C: HIV/AIDS:

Refugees 15 years or older are tested for HIV prior to entering the United States. Refugees younger than 15 are only tested if there is reason to suspect they may have HIV, such as a parent who is HIV positive. HIV positive refugees may apply for an admissibility waiver in order to be resettled in the United States.

To have an admissibility waiver approved on the grounds of HIV status a refugee must be accepted by a VOLAG in the state in which he/she will be resettled. The refugee is also counseled about his/her HIV+ status and must agree to prevent the spread of HIV and maintain compliance with his/her treatment protocol.

Medical care management for HIV+ refugees is provided by the Miriam Hospital Immunology Clinic during and beyond the eight months of medical coverage administered through the Medicaid Program.

HIV Infection

"Having AIDS in our culture from a social perspective is a complete catastrophe. AIDS is considered a terrible disease and is extremely shameful. If you have it, you lose your friends and family, you might be cast out by society and left on your own. It is almost better to die than to tell people that you have AIDS".

Ethiopian Woman[3]

IV-D: Oral Health

Many refugees arrive with advanced or untreated dental disease. Most have received limited or no oral health care for years. Many suffer from periodontal disease, caries, gingivitis and calculus, and tooth decay. Deficiency levels vary according to their countries of origin. Refugees from poorer countries may show lower levels of decay (due to plain food and no sweets). Many refugees, especially those who have been transferred from one refugee camp to another and have been marginalized because of language, social and economic factors subsequently develop high levels of oral health deficiencies.

IV-E: Lead Screening

In 2006, the CDC issued revised lead screening recommendations for refugee children. In accordance with the CDC recommendations, the Rhode Island Department of Health also issued revised lead screening guidelines for refugee children.[3] Refugee children through 16 years of age should have a venous blood lead test performed at the refugee health screening and regardless of the result, a follow-up test should be administered 3-6 months after arrival. Providers should report initial lead screening results on the Rhode Island Refugee Health Screening form. Children with elevated blood lead levels should be referred to a Lead Center per the guidelines.[4]

IV-F: Nutrition and Diet

Many health problems among refugee groups may be related to diet and lifestyle. Some of the issues are as follows:

- Inadequate diet: sometimes related to unfamiliar foods; vulnerable micronutrients include iron, vitamin A, vitamin D and iodine. Anemia is common, especially in women and children.

- Refugee children may have had previous periods of acute and/or chronic poor growth due to inadequate energy intake, illness or both. Inadequate nutritional factors could include insufficient breast milk or formula, inadequate introduction of solid foods, food allergies or intolerance.

- Inadequate water intake: refugees may have spent long periods of time without access to safe water and may need encouragement to drink tap water.

- Limited education regarding the potential harmful effects of food: for example, the relationship between dental caries and sugar consumption, or high fat foods and obesity, or weight and diabetes.

- A decline in breastfeeding: bottle-feeding may be seen as a modern, better alternative.

- Lack of local knowledge about shopping for healthy food choices and food preparation among refugees, especially among adolescents and single men.

IV-G: Mental Health

Health practitioners should be aware of the following mental health issues among refugees resettled in the United States:

- Anxiety and depression
- Eating disorders
- Post traumatic stress disorder (PTSD)
- Psychosomatic disorders
- Substance abuse

Mental health issues are often overlooked in health service policies. Both African and Southeast Asian countries are still confronted with so many problems caused by communicable diseases and malnutrition that they may not consider the impact of mental disorders.

Studies reveal that refugees have been subjected to severe trauma and torture as well as psychological or physical violence. Many suffer significant psychological sequelae and are diagnosed with anxiety disorders including post-traumatic stress disorder (PTSD).

The education of refugees and their families as well as of health providers is an extremely important matter when treating refugees who suffer any of the mental health problems mentioned above.

References:

1. The New England Journal of Medicine, Volume 321:1301-1305
2. CDC – Enterically transmitted non-A, non-B hepatitis – East Africa
3. Refugee Health Care: A Handbook for Health Professionals, Physical Health Care, Minister of Health, New Zealand, November 2001
4. RI Lead Screening and Referral Guidelines for Refugees: http://www.health.ri.gov/lead/family/Final_Screening_Guidelines.pdf

V

THE HEALTH STATUS OF REFUGEE CHILDREN & ADOLESCENTS

Risk factors and diseases that increase morbidity and mortality in dependent refugee populations in developing countries include malnutrition, diarrheal diseases, measles, malaria and pneumonia.[1] Women and children are especially vulnerable to these conditions. However, the severity and magnitude of these diseases are often exacerbated by conflict or disaster, necessitating rapid assessment and treatment of large numbers of severely ill children.

V-A: Diarrheal Diseases

Diarrheal diseases represent a major health problem in developing countries. Each year at least four million children under 5 years of age die from diarrhea, mainly from Rotavirus, Colibacillus, and Shigella (Shigella being one of the most serious diseases). An inadequate water supply, poor sanitation, overcrowding, and malnutrition are the main factors in the spread and severity of diarrheal diseases. Malnutrition and diarrhea are particularly closely linked: malnutrition increases the severity and duration of diarrhea, and diarrhea in turn may cause malnutrition. In refugee populations, epidemics of severe diarrheal diseases are often caused by Shigella and Cholera.

- **Shigella Dysentery Type 1**
  Shigella is highly contagious. The ingestion of as few as 10-100 bacteria can cause the disease (in contrast to the cholera infective dose, which is counted in the millions). Shigellosis is endemic throughout the world where it is held responsible for some 165 million cases of severe dysentery with blood and mucus in the stools, the overwhelming majority of which occur in developing countries and involve children less than five years of age. More than one million people are estimated to die from Shigella infection each year. Since the late 1960s, pandemic waves of Shigella dysentery have hit sub-Saharan Africa and Southeast Asia, often striking areas of political upheaval and natural disaster. During the 1994 genocide in Rwanda, approximately 20,000 Rwandan refugees who had fled into the North Kivu region of Zaire died in the first month alone from dysentery caused by a strain of Shigella that was resistant to all commonly used antibiotics. The combination of Shigella and HIV infections has deleterious consequences, due to compromised immunity in HIV-positive persons.[2, 3]

- **Cholera**
  Cholera is an acute illness characterized by watery diarrhea. The toxin released by the bacteria causes increased secretion of water and chloride ions in the intestine, which produces massive diarrhea. Death can result from the severe dehydration. Cholera can occur in epidemics when conditions of poor sanitation, crowding, war, and famine are present. The most acute symptoms are the sudden onset of watery diarrhea (up to 1 liter per hour) which has a "rice water" appearance and a "fishy odor". Cholera is extremely contagious. Of people infected with cholera, most do not have symptoms and up to 50 percent of severe cases die. In Goma, Democratic Republic of Congo, during the first weeks of the Rwandan refugee influx in 1994, it was estimated that there were between 58,000 and 80,000 cases with 1000 cholera-related deaths per day, out of an estimated population of 500,000 to 800,000 refugees.

- **Capillariasis**
  Capillariasis is a nematode infection of the intestines. Most infections are the result of eating infected raw fish. Onset is quick and includes abdominal pain and watery diarrhea. The patient may become re-infected by larvae from the previous infection. The second infection may cause ongoing disease of the intestinal tract, protein loss, and can severely inhibit the patients' ability to absorb nutrients.

- **Chikungunya**
  Chikungunya is transmitted by mosquitoes and has an incubation period of approximately 2-4 days. It resembles Dengue. The acute symptoms last for 3-10 days and can include an abrupt onset of fever, headache, joint pain, nausea, vomiting, abdominal pain, sore throat, enlarged lymph nodes, rash, and malaise. Joint pain may remain a problem for several weeks to several months after the acute phase. Fever and convulsions may occur in young children.

- **Cryptosporidiosis**
  Cryptosporidiosis enteritis is an infection of the small intestine that is caused by the parasite cryptosporidium. This parasite causes diarrhea in all age groups. It impacts individuals with compromised immune systems. The major source of this infection is contaminated water. Symptoms include watery diarrhea several times a day, abdominal cramping, nausea, and exhaustion.

V-B: Acute Respiratory Infections (ARI)

In developing countries, approximately 4 million children die every year from ARI. Ninety percent of those deaths are attributable to pneumonia. Children with low birth weight and those suffering from malnutrition are at especially high risk. Factors that encourage ARI are: malnutrition, vitamin A deficiency, chilling in infants (due to poor shelter), overcrowding, and indoor pollution (e.g., bad ventilation in shelters).

V-C: Malnutrition

Malnutrition is a common problem among refugees and is a major contributor to a variety of health problems. Inadequate food rations contribute to high malnutrition prevalence among children aged less than 5 years. This is often due to the remoteness of some of the refugee camps, difficult logistics of food transport and storage, and the limited variety of food items supplied to refugees. Imprecise refugee population counts also contribute to the distribution of inadequate food rations. Malnutrition is the result of decreased intake of one or all food groups or to decreased absorption of nutrients due to illness. Diseases and malnutrition often form a vicious cycle. Malnutrition contributes to a diminished immune system, which makes individuals more susceptible to diarrheal illnesses, which in turn leads to decreased absorption of nutrients.

- **Anemia**
  Iron-deficiency anemia (IDA) in refugee children is a major medical problem. Iron deficiency (ID) is considered the most prevalent micronutrient deficiency in refugee populations.[6] Southeast Asia has one of the highest overall prevalence rates of anemia with approximately 616 million people at risk or affected by iron deficiency (ID) or anemia. In areas where the prevalence of anemia exceeds 30-40%, the majority of anemia appears to be caused in part or exclusively by ID.[5] It is estimated that one-half of the children in developing countries and in refugee camps are iron deficient and the highest risk groups are preterm and low birth weight infants, and infants and children during periods of rapid growth.

- **Acute or Severe Malnutrition**
  Adolescents and children suffer from acute malnutrition as a result of a relatively recent decline in nutritional intake. It is characterized by the following illnesses.

  — **Marasmus**
  Marasmus is due to inadequate caloric intake and is characterized by failure to gain weight, and weight loss resulting in emaciation. Indications of the condition include the loss of subcutaneous fat, which causes poor turgor and wrinkling of skin. Skin turgor is an abnormality in the skin's ability to change shape and return to normal (elasticity). The degree of resistance to deformation is determined by various factors, such as the amount of fluids in the body (hydration) and age.

  — **Kwashiorkor**
  Kwashiorkor or protein-calorie malnutrition (PCM) may be due to inadequate intake or absorption of protein in children. Kwashiorkor is commonly seen in children around 2 years and/or those who have recently been weaned. Initial symptoms are lethargy or irritability and progress into anorexia, increased weakness, decreased muscle tissue and retarded growth. If untreated, the child develops hepatomegaly, kidney function decreases, and cardiac function is impaired. Indications of the condition include pitting edema in the legs and feet. Skin changes include dermatitis, changes in pigmentation, and changes in hair. Typically, hair is sparse, thin, and often streaked with red or gray color. The condition impairs the immune system function, leaving the child vulnerable to infection.

— **Cachexia**
Cachexia is a metabolic disorder marked by general ill health and malnutrition, with weakness and emaciation. In cachexia, there is approximately equal loss of fat and muscle, significant loss of bone mineral content, and the body does not respond to nutritional supplements or increased intake.

— **Chronic malnutrition**
This is generally a result of perinatal childhood malnutrition or prolonged periods of time with insufficient intake. While many children who experience childhood malnutrition survive and reach adulthood, they are more likely to have long-term developmental problems such as loss of intellectual potential or incomplete physical (stunting) or mental development. A major concern with chronic malnutrition is the impairment of the immune system.

— **Micronutrient deficiency**
Micronutrient deficiency is another form of malnutrition that is potentially a significant issue for most refugees. This is particularly common in groups with little or limited diversity in diet. Children are severely affected by deficiencies in iron (iron deficient anemia is common), vitamin A, iodine, and folate that can lead to low-birth weight, stunting, blindness, mental and developmental delay and birth defects.

V-D: Common Psychosocial and Mental Health Conditions

While it might appear that children cope well and come to terms with what they have lost, the long-term effects of their experiences may not find expression until adulthood. Adolescent children in particular may experience difficulties. Some may be caught uncomfortably between two cultures. Mixing with the opposite sex may be unacceptable in their community's eyes. They may feel confused and frustrated by differing with the expectations of the receiving country. Many boys and young men, in the absence of a father, find themselves in the role of head of the family at home, and in the role of a "kid" at school. Young people who experience hostility and indifference in the new culture and have limited opportunities may drift into drugs, drinking, gambling or criminal activities. At the same time, they may become depressed, withdrawn or experience psychosomatic disorders.

V-E: Social Norms and Adolescents [6]

"During conflict and displacement, new adolescent reproductive health needs are created. New challenges therefore arise:

- The breakdown of social networks is particularly damaging to adolescents because these networks provide the emotional and psychological support to guide their sexual development. The absence of traditional forms of guidance in the transition to adulthood may result in earlier and increased risk-taking behavior.

- The boredom, hopelessness, uncertainty, insecurity and frustration of refugee life can also result in risk-taking behavior. Besides unsafe sexual activity, other risk-taking behavior includes tobacco, drug and alcohol abuse, poor nutrition, and violence inflicted both by and on adolescents. The desire to plan for the future may diminish, affecting adolescents' motivation and ability to take the necessary steps to avoid STIs, HIV and unwanted pregnancy.

- Adolescent girls (both married and unmarried) who become pregnant may find themselves without the support to cope with pregnancy, childbirth and raising a child.

- The risks of unsafe abortion may be exacerbated when both social support networks and health services are disrupted.

- In peacetime, young adolescent girls, whether married or single, run the highest risk of sexual violation. In conflict and displacement, this situation is likely to be aggravated.

- Unaccompanied minors, whether boys or girls, are especially vulnerable to violence and other forms of sexual exploitation. They may turn to prostitution in order to survive. They are also far more vulnerable to other forms of high-risk behavior, including substance abuse, and to poor health in general.

- The idea of aggressive masculinity inculcated in child and adolescent soldiers can have a profound and long-term negative impact on their own reproductive health and on that of the communities with which they come into contact".

The impact of extreme stressors on children, including diseases and human-made disasters is substantial. Besides stressors on a day to day basis, surviving children and adolescents may experience injuries or be exposed to distressing events including witnessing someone dying, being injured, seeing dismembered bodies, or being separated from their families (UNICEF:2004). One of the most traumatic events is losing their familiar environment, such as their home, school or peers. At the same time (and if the family is still in existence), the caregivers may not be able to provide the care and comfort needed. Anxiety, fear and a sense of insecurity are common and manifest through many reactions that may differ according to age.

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VI

LINGUISTICALLY APPROPRIATE SERVICES FOR REFUGEES

VI-A: Linguistic Services for Refugees

Most refugees will need translation and/or interpreting services. This is particularly important during the medical examination and follow-up. (See: **CLAS Standards**, Appendix G). It is worth mentioning that although some of the groups may speak English in the grammatical form, sentence structure and vocabulary may be very different from American English. Accents may also make it difficult to understand or be understood.

VI-B: National Standards for Culturally and Linguistically Appropriate Services in Health Care

The increasing diversity of the nation brings with it a host of opportunities and challenges that are experienced with increasing frequency and immediacy in health care facilities, from small rural clinics to large urban medical centers. Sensitivity, empathetic listening, and a little extra effort can often go a long way to bridge the gap between the staff of health care organizations and patients who bring cultural differences to the health encounter. Consequently, many national, state, and local policymakers have also recognized the importance of cultural competence in facilitating accessible and effective health care for culturally diverse populations. The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) provide mandates, guidelines, and recommendations for recipients of federal funding regarding the provision of culturally and linguistically appropriate services in healthcare settings. These standards were released in 2001 by the federal Office of Minority Health in response to Title VI of the Civil Rights Act. Of the fourteen CLAS Standards, four (#4-7) are mandates enforceable by the Office of Civil Rights. The mandates speak to the issue of language access and require the provision of trained interpreters and translated materials. For further information, please see Appendix G.

CLAS Mandates

4. Offer and provide language-assistance services
5. Inform patient of language assistance rights
6. Assure competence of interpreters; family members should not interpret except at patient's request
7. Patient-related materials and signage in languages of commonly encountered groups

VI-C: LANGUAGES SPOKEN

The following languages are commonly spoken among some of the refugee populations in Rhode Island:

Somali-Bantu
Maay Maay
Somali
Arabic

Hmong
Hmong
Laotian
Thai

Liberian
Krahn
Liberian English
French
Mandingo

Burmese
Burmese
Thai
Karen languages

Burmese
Burmese
Thai
Karen languages

Burundians
Rundi
Kiswahili
French

VI-D: Interpreting Services in Rhode Island

Because refugees speak many languages other than English, interpreter services are often necessary. Ideally, health care providers themselves will be bilingual, or will employ trained and qualified interpreters. If this is not possible, there are agencies in Rhode Island and nationally who can be contracted to provide interpreter services. RIte Care covers interpreting services as long as the services are pre-arranged. In this case, the provider or the patient must call the RIte Care Plan-United, Neighborhood Health Plan or Blue Chip to schedule an interpreter in advance of the appointment. The interpreter will attend the appointment. The provider should not bill separately for this service; it will be billed directly to the insurer by the interpreting service.

Phone Interpreting services are used when an interpreter for a certain language is not available. A RIte Care insurer may refer the provider to a phone interpreter service or the provider's agency may have a pre-existing contract with a phone interpreting service. Though less desirable than having a live, qualified interpreter, this method has been useful for interpretation of less commonly spoken languages.

Video interpreting has also been used by providers to create a video and audio connection to an interpreter in a remote location. Though more costly than phone interpretation, this tool should also be considered by providers.

VII

CULTURAL PROFILES

In the sections that follow are culture and health profiles of refugee populations resettling in Rhode Island. These profiles are neither exhaustive nor uniformly applicable. Providers must keep in mind that every individual is unique and will respond to shared experiences differently. The information presented in these profiles is meant to facilitate understanding and prompt further inquiry. Periodically, the Refugee Health Program will produce additional cultural profiles of arriving refugee populations to add to this manual. Cultural profiles can be downloaded from the Refugee Health Program webpage at www.health.ri.gov.

VII-A: SOMALI BANTU HEALTH SHEET

History and Background

The Somali-Bantu are one of many Bantu-speaking groups throughout Africa. They form a distinct group within Somalia with its own distinct problems. Brought to Somalia as slaves from Tanzania and Mozambique in the 18th and 19th centuries, they have been continually marginalized within the Somali society. Somalia's government fell in 1991 leading to civil war. Mass starvation ensued, and since the Bantu formed the backbone of agricultural production, they were often targets of attacks by bandits and militia. Since the Bantu fell outside of the existing clan based system, they had no protection against such attacks. The theft of food supplies was accompanied by acts of burglary, rape, and murder. Up to 12,000 Somali-Bantu were displaced to Kenya, with a smaller number finally escaping to Tanzania. Refugee camps were located in arid, difficult conditions and the Bantu suffered a disproportionately large number of attacks and rape in the camps. Resettlement was sought to Tanzania in 1993 and 1994 and to Mozambique in 1997 and 1998, before being sought to the United States in 1999. Despite the end of the Civil War in Somalia, the Bantu still face constant threat from bandits and face widespread discrimination from the rest of society.[1, 2]

Pre-migration	During flight & refugee camps	Post-migration & Resettlement
Exposure to infectious and parasitic diseases, physical and psychological trauma	Malnutrition, exposure to the elements, exposure to infectious and parasitic diseases, physical and psychological trauma	Increasing susceptibility to chronic diseases, problems and stressors of resettlement (racism, unemployment, crime, etc.)

Common Health Considerations

Health practitioners should be aware of the following possible medical concerns among the Somali Bantu resettled in the United States:

- Sexually Transmitted Diseases
  - — HIV/AIDS:
    The prevalence in Somalia is only 1%, however this can be as much as six times higher in refugee camps. Somali refugees should be considered to be at significant risk.
  - — Sexually Transmitted Diseases are more common in refugee camps.
- Communicable Diseases
  - — Tuberculosis
  - — Diarrheal disease
    Tuberculosis and diarrheal disease are responsible for 16.9% of deaths in Somali children
  - — Shigellosis
  - — Cholera
  - — Pneumonia
    Shigellosis, cholera and pneumonia are responsible for 41% of deaths in Somali children
  - — Measles
  - — Meningococcal Meningitis
  - — Lice and Scabies
  - — Hepatitis B
  - — Typhoid Fever
  - — Trachoma
  - — Dengue Fever
  - — Hansen's Disease
- Intestinal Parasites
  These often lead to anemia, anorexia, and diarrhea
  - — Strongyloides
    Somali Bantu refugees should be presumptively treated for Strongyloidiasis
  - — Ascaris
  - — Tapeworms
  - — Giardia
  - — Hookworm

— Enterobius
— Trichuris

- Non-Intestinal Parasites
  - — Filariasis
  - — Leishmaniasis
  - — Schistosomiasis
    Somali Bantu refugees should be presumptively treated for Schistosomiasis
  - — Roundworms
  - — Malaria
- Female Genital Cutting (FGC)/Female Genital Mutilation (FGM)
  This is common among girls 8–10 years of age, and can lead to:
  - — Chronic Pelvic Infections
  - — Infertility
  - — Cervical cancer
  - — Post Traumatic Stress Disorder
  - — Maternal Morbidity and Mortality
- Malnutrition
  - — Iron-Deficiency Anemia
    44-71% of pregnant Somali's are anemic
  - — Low birth weight children
  - — Vitamin A deficiency (Xerophthalmia)
- Dental Caries
- Mental Health
  WHO estimates that 50% of refugees suffer from mental disorders
  - — Post Traumatic Stress Syndrome
  - — Depression
  - — Anxiety
- Recommended Laboratory Tests for Somali-Bantu refugees:
  - — Nutritional assessment
  - — Stool for ova and parasites
  - — Hepatitis B surface antigen
  - — Hemoglobin or hematocrit
  - — VDRL
  - — HIV
  - — PPD
  - — Peripheral smear for malaria should be considered

Being a historically rural people, the practice of traditional healing methods is widespread among the Bantu. This may include applying a heated nail to an infant's head to reduce an unusually large head or burning a small hole in the skin to cure minor ailments like stomach aches and migraines. Some women perform ritual ceremonies with the help of traditional healers, known as *Gitimiri* or *Audara*, to cast off illness and evil spells. [1,4]

Family and Social Structure

- The societal structure is markedly fractionated by membership in patrilineal clans (descent through male lines).
- Men and elder family members are assigned positions of highest respect by religious traditions.
- Loyalty, peace, harmony and health promote the stability of the *"spiritual unity"* of families. Cooperation and responsibility of role functioning supports *"social unity".*
- Patterns of family interaction direct women to defer to men, especially in public.
- There is a limited form of polygymy traditionally practiced among the Bantu. However, to be allowed to settle in the United States, only one wife can be chosen with the others being divorced. This has further lead to a fragmentation of families. Upon resettlement many former wives have resettled near their former husbands. [5]
- Loss of extended family support creates increased stress for resettled family members.
- There is a strict separation of the sexes. Women, including prepubescent girls, are expected to cover their bodies, including hair when in public.
- An ideal Bantu family consists of between 4-8 children. The extended family includes grandparents, uncles, aunts, and other relatives.
- A married woman retains membership in her father's family.
- A two-parent family structure describes the ideal form for Somali families. There are words for divorced and widowed women but not for "single mother" (it violates religious family structure).
- Somali family conflict management strategies require arbitration by the elderly.

Reproductive Health

- Contraception and abortion are strongly opposed by most Somalis, given the strong belief that pregnancy is a blessing from God.

- Sexing of the fetus is not encouraged, as it is considered God's will and cannot be changed.

- Specific to Bantu women, the experiences of circumcision, rape, lack of education, second-class status in Somali society, high birth rates, single parent status and trauma from past experiences require appropriate social services, ensuring as much as possible that people belonging to the same social support network are resettled in the same geographic location.

- FC/FGM is performed throughout Somalia on girls between the ages of four and ten, and has a prevalence of over 95%. Infibulation, the extreme form of FGM, is the most common cause of difficult or prolonged delivery, and is one of the main causes of maternal mortality. It affects the physical, mental and psychosocial wellbeing of girls and women.

- Gynecologic complications may occur as a result of FC/FGM including tetanus, chronic pelvic infection, urinary tract infection, infertility, incontinence, difficulty with urination and menstruation; obstetric complications of FC/FGM include severe perineal lacerations, obstructed labor, fistulas, and uterine rupture.

- Women may experience difficulty with sexual intercourse because of the reduced size of the introitus, or vaginal opening after FC/FGM. For the same reason, pelvic exams may be physically painful and difficult.

- The history of sexual abuse among many refugee women may evoke strong emotional and psychological responses to gynecological exams.

Maternal and Child Health

- In Somalia, current indicators relating to children and women's welfare demonstrate an almost universal deterioration of statistics compared to before the war period.

- There is a high birth rate among this population: 29% of deliveries in Kakuma since July 2002 were Somali Bantu despite the community representing only 12% of the total population of the camp. Data from UNICEF notes that maternal mortality (MMR) is estimated at 1600 per 100,000, placing Somali women among the most high-risk groups in the world. Approximately 1 in 48 women are at risk of dying from a pregnancy or childbirth related complication. Because Somali women do not practice birth spacing, the mortality rates in infants is high and the prevalence of low birth weight infants is common.

- Most women fear Caesarean section delivery, as it is thought that the surgery may impede subsequent pregnancies.

- Anemia is common among pregnant women in Somalia. Malaria and other parasitic diseases can cause severe disease or worsen pre-existing iron deficiency anemia.

- Hemorrhage, prolonged and obstructed labor, infections and eclampsia are the major causes of death at childbirth. Anemia and female genital mutilation (infibulation) have a direct impact on, and aggravate these conditions.

- There is a high prevalence of low birth weight infants. Nineteen percent (19%) of Somali Bantu infants born in Kakuma since July 2002 had a low birth weight.

- Childbirth most often takes place at home, attended by a midwife. The new baby and mother stay at home for 40 days after birth, with female relatives and friends helping to care for both.

- Newborn care includes warm water baths, sesame oil massages and passive stretching of the baby's limbs.

- Diapering is not common in Somalia. When the baby is awake, the mother holds the baby in a sitting position over the basin. At night, plastic is placed between the mattress and the bedding. The bedding and plastic are cleaned daily. Somali mothers say infants are toilet-trained in a short period of time.

- Women may reduce their food intake in order to limit the size of their baby and prevent a difficult birth after experiencing female genital cutting/female genital mutilation.

- Women often stop breastfeeding as soon as they become pregnant and start weaning their children before the recommended age of 6 months.

- Breastfeeding is common but the feeding is usually supplemented with animal milk (camel, goat or cow). The animal milk is offered with a cup rather than a bottle.

- Quality of care is affected when a mother must also attend to a high number of young siblings. Malnutrition in these children may result from chronic disease exacerbated by inappropriate food intake and caring practices.

- The rates of child morbidity and mortality in Somalia remain among the highest in the world. A survey undertaken in 2000, the Multiple Indicator Cluster Survey (MICS) estimates the infant mortality rate (IMR) at 132 per 1000 and Under Five mortality rate (U-5MR) at 224 per 1000 (UNICEF). Leading health problems of Somali Bantu children are pneumonia (41% of deaths), malaria (24.5% of deaths) and watery diarrhea (16.9% of deaths).

- Poor antenatal and postnatal care, with the almost complete lack of emergency obstetric referral care for birth complications, further contribute to these high rates of mortality and disability.

- In the United States, Somali refugees prefer female examiners. Bantu women will be further challenged if they cannot draw upon their extended family and kin networks to assist them with child rearing and moral support.

Diet and Food

- Due to the diet of the group (mostly maize, known as "*soor*", which is a thick porridge), beans, sorghum, lentils, some vegetables and fruit, there are micronutrient deficiencies. In the USA, those refugee families coming from Western and Central Africa continue their traditional diet, eating no less than twice a day — rice, fulu (a starchy accompaniment for stews or other dishes with sauce), cassava and plantains.

- Deficiency diseases include, in addition to the most common iron and vitamin A deficiencies, scurvy (vitamin C deficiency), pellagra (niacin and/or tryptophan deficiency) and beriberi (thiamin deficiency).

- Regular supplementation of specific vitamins (e.g. vitamin C, vitamin B complex) is advisable.

- There is a need for dietary diversification. This can only be achieved by counseling refugees regarding healthy diets.

- The Somali's food diet is so different from the USA diet, that only through education, training and counseling can the diet be diversified enough to achieve the desired healthy nutritional outcomes.

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VII-B: Hmong Health Sheet

History and Background

The Hmong population lived in the highlands of Southern China, and resided in Laos, northern Vietnam and Thailand. Actively recruited by the CIA and US Army during the Vietnam War, thousands fled to Thai refugee camps after Laos fell to the communist Pathet Lao movement. Due to the threat of repatriation, many left the Thai camps and took refuge in Wat Tham Krabok, a Buddhist temple in Central Thailand. Most refugees spent several years in the camps and were then resettled in a third country. The case for Hmong applying to come to the U.S. was especially compelling due to American promises of assistance if Laos fell to communists. Initially, resettlement of the Laotian and Hmong refugees was substantial, but in recent years the numbers have dwindled.

The Hmong were always considered the "mountain people", and were considered an ethnic minority in most of the areas where they lived. Consequently, Hmong people have had a relatively low social status. [1, 2]

3

Pre-migration	During flight & refugee camps	Post-migrational & resettlement
Exposure to infectious and parastitic diseases, physical and psychological trauma, tuberculosis, syphilis, scabies	Malnutrition, exposure to the elements, exposure to infectious and parasitic diseases, physical and psychological trauma	Increasing susceptibility to chronic diseases, problems and stressors of resettlement (racism, unemployment, crime, etc.) Cardiovascular disease, Invasive cervical cancer in women, Sudden Unexpected Nocturnal Death Syndrome (SUNDS), Hepatitis B, Substance Abuse

Common Health Considerations

Health practitioners should be aware of the following possible medical issues among the Hmong refugees resettled in the United States:

- Sexually Transmitted Diseases
  - — HIV/AIDS:
    The rate of HIV/AIDS among Hmong at the Wat is unknown. However, the rate among the general Thai population is 1,024/100,000. Furthermore, a 1995-96 HIV/STD risk assessment reported that 15% of participating Hmong youth personally knew a Hmong person with HIV or AIDS.[4]
  - — Chlamydia
  - — Syphilis
    Sexually Transmitted Diseases are more common in refugee camps.

- Communicable Diseases
  - — Multi-drug resistant TB
    In January 2005 reports of Multi-Drug resistant TB among Hmong refugees led to a 1-month travel suspension. As of July 15, 2005, no new cases were diagnosed among newly resettled Hmong refugees. The CDC recommends careful monitoring for TB among this refugee group.
  - — Avian Influenza
    Avian influenza has been circulating among the poultry flocks of Thailand. If individuals show symptoms typical of influenza and are known to have traveled to areas where Avian influenza was prevalent in the past 10 days, Avian influenza may be suspected.
  - — Leptospirosis
  - — Meliodosis
  - — Mycetoma
  - — Measles
  - — Hepatitis
    Research has shown high rates of chronic hepatitis B among the Hmong and other Southeast Asian populations
  - — Typhoid and Paratyphoid Fever (or Enteric Fever)
  - — Trachoma
  - — Cholera
  - — Yaws
- Parasites
  Due to their living conditions in their home countries and in refugee camps, the Hmong are highly susceptible to parasite infections.
  - — Amebiasis
  - — Angiostrongyliasis
  - — Capillariasis
  - — Chikungunya
  - — Clonorchiasis
  - — Cryptococcus
  - — Cryptosporidiosis
  - — Cysticercosis
  - — Filariasis
  - — Gnathostomiasis
  - — Helminthiasis
  - — Hookworm
  - — Leishmaniasis
  - — Malaria
  - — Leprosy
  - — Scabies
  - — Schistosoma
  - — Strongylodiasis
  - — Trichuriasis
  - — Trematodes

- Malnutrition
  - — Acute or severe malnutrition
  - — Marasmus
  - — Kwashiorkor or Protein-Calorie Nutrition (PCM)
    - *Observations indicated a potentially high incidence of protein malnutrition among children 2 years and older*
  - — Chronic Malnutrition
  - — Micronutrient Deficiency
- Chronic Conditions
  - — Arthritis
    - *Examinations have shown a high prevalence of arthritis among the Hmong.*
  - — Asthma
    - *Hmong from the Wat Tham Krabok in Thailand live near a stone quarry and there are reports of high numbers of respiratory illnesses. Up to 25% suffer from asthma.*
  - — Diabetes
  - — Cardiovascular ailments
- Oral Health
  - *Surveys have shown that up to 60% of Hmong refugees at the Wat have serious dental problems.*
- Mental Health
  - *WHO estimates that 50% of refugees suffer from mental disorders*
  - — Post Traumatic Stress Disorder
  - — Depression
  - — Anxiety
- Other
  - — Tropical Sprue
  - — Thalassemias
    - *Alpha Thalassemias is most common in Southeast Asia and China.*
  - — Sudden unexplained nocturnal death among adult males
    - *Similar to reports among other Asian immigrants.*
  - — Asymptomatic Splenomegaly
    - *Three times the rates of other Indochinese refugees.*

Most Hmong refugees relied on traditional medicine for their health problems. Illnesses are believed to have a spiritual cause, such as the loss of souls or offense to ancestors or non-spiritual causes such as environmental exposure. Souls can be lost by accident, by a frightening event or by an angry spirit and the illness would get worse if the soul is not returned. Herbal medicines and spiritual ceremonies are commonly used by the Hmong for health purposes. Gentle pinching, cupping or coining is used for non-spiritual illnesses which may result in bruising that may be confused with physical abuse. Traditional medicines made from herbs, bark, or animal parts are often used first and if they fail then a Shaman may perform a ceremony to restore the person's soul.[2, 5]

Family & Social Structure

- The Hmong social structure is centered on large extended families within 18 organized clans.
- Nuclear families average 6.4 persons, although this is changing for Hmong men and women who are raised in the United States.
- The Hmong lived in agricultural areas; consequently, large families brought economic advantages as well as social and spiritual support.
- The Hmong marry at a young age, often during the teenage years.
- Hmong men and women often have the same name, and Hmong traditionally take an adult name, added to their first name, after they marry and their first child is born.
- Culturally, Hmong are similar to other Asian groups. Hmong value interdependence, group-reliance, communal survival and cultural tradition. They have a tendency to keep their feelings and opinions to themselves compared to the US culture. They believe hard work is the way to success.
- Linguistically, "Hmong" did not have a written language until the French missionaries invented one in the 1950's. The Hmong language is completely different from English. It is a tonal language, consisting of eight tones. The final consonant of a word is the tone of that word and it is not pronounced. Words with the same pronunciation but different tones have different meanings. There is no gender system or plural nouns in Hmong.

Reproductive Health

- The Hmong refugees were traditionally patriarchal and have lower education levels. Polygamy was practiced and girls married early in their teens and bore children soon afterwards. Fertility was higher among this group and women were usually unwilling to make family planning decisions without the permission of their husbands.

- The reproductive health needs of adolescents focused primarily on safe pregnancy care. Most women did not practice family planning until they had achieved their desired family size.

- Menarche may be later for Hmong and early menopause is common

- Rates of contraception are low because of the value placed on big families.

- It is believed that blood is retained in the womb if a period is missed.

- Menstrual blood is seen as a pollutant.

Maternal and Child Health

Antenatal care

- Poor maternal health and nutrition during pregnancy and delivery and inadequate reproductive health care for women are still problems, especially in rural areas.

- Hmong women may refuse vaginal examinations, especially by male doctors. This may be a reason for late presentation for antenatal care and non-attendance at post partum checks.

- Heavy workloads are undoubtedly a significant factor in maternal malnutrition. Women often continue working until the time of delivery. The mean weight gain during pregnancy varies from 6.6 to 8.5 Kg. in urban areas.[7]

Birth

- In Hmong culture, mothers and mothers-in-law help at the birth, which often occurs in the squatting position, with the husband helping to cut the cord and wash the newborn infant. Women prefer natural tearing and healing to episiotomies. A woman requiring a Caesarean section under general anesthetic may have concerns that when her body is cut her soul will be lost.

- In districts implementing community-based safe motherhood activities it was found that only 23% of women had a safe delivery, including adequate antenatal care and post-natal care.[6]

- Most maternal morbidity is caused by poor maternal nutrition and various reproductive health problems. General malnutrition and specific micronutrient deficiencies are widespread.

- The prevalence of iron deficiency anemia among prenant women is very high. Together with low Body Mass Index (BMI) and iron deficiency anemia, inadequate weight gain during pregnancy correlates with low birth weight. Low BMI during breastfeeding contributes to poor infant growth. Iron deficiency and anemia are also common in infants (especially low-birth-weight infants) and young children, where anemia is often the result of the combination of several facts: Iron deficiency; parasitic infections (hookworms, schistosomiasis or malaria; nutritional deficiencies (folic acid, vitamins B12, A and protein –energy malnutrition).[8]

- Reproductive tract infections (RTIs), sometimes related to poor hygiene, put women at higher risk of pre-and post-partum infection and can lead to premature deliveries.

- Birth registration has recently emerged as a growing concern in the country. Nonetheless, coverage of birth registrations is difficult to estimate. In rural areas it can be between 70 and 90% and low or non-existent in others; many children are registered late.

- The placenta is required for reincarnation and is usually buried at the place of birth. This should be discussed with women antenatally.

- According to the World Health Organization, the maternal mortality rate (MMR) at present is between 160 and 130 per 100,000. There are disparities in MMR between rural and mountainous areas. In 1990, the MMR was estimated to be 220/100,000.

- Unhygienic deliveries, limited access to trained health staff during delivery and very limited essential obstetric care (EOC) are believed to be the main underlying causes of maternal mortality.

Post-partum

- In the Hmong tradition, the first 30 days after birth are seen as the most dangerous period for a new mother.

- It is customary to keep warm for three days post-partum. Touching cold water post-partum is prohibited. While previously women lay by fires, women today may wear warm clothes and use heating. Hmong women in hospitals post-partum will often not eat the hospital diet, as traditionally they should eat hot rice and chicken soup with special herbs. Eggs, pork and some fish may be allowed after the first 10 days. No fruit, vegetables or cold drinks are allowed during confinement. Physical activity post-partum is also restricted, as this may cause "collapse of the internal organs".

- The Hmong continue to observe their post-birth confinement practices regardless of their new environment. Most women mentioned that this is to avoid ill health and misfortune in the future.

Infants

- Hmong babies are on average 200g lighter than babies from most other Southeast Asian populations. A necklace is placed on the newborn baby's neck to protect the infant from ill health and harmful agents. Praising the newborn may cause harm to the baby from the spirits. The newborn may therefore be greeted by expressions such as "you are ugly" in order to fool the spirits and protect the baby.

- The Mongolian blue spot (sometimes mistaken for neglect) is a bluish pigmentation in the lumbo-sacral region and is common among Indo-Chinese and other Asian babies up to two years.

- Vitamin A deficiency among pregnant and lactating women can lead to night blindness and xerophthalmia among infants.

Diet and Food

- The Hmong have maintained strong ties to their native food and traditional meal patterns.

- Rice remains the staple food in their diet. Fruits, meats and soft drinks remain highly preferred in the United States. While milk is well liked, cheese remains a strongly disliked food item. Fruits and vegetables are frequently consumed.

- In moving to the United States, the Hmong people may find it difficult to continue their traditional diet. Children become "Americanized" in their preferences. For these reasons, among Hmong youth, obesity is a significant and growing problem.

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VII-C: Liberian Health Sheet

History & Background

Liberians constitute a very diverse group of people who all hail from the same country. The population can be roughly divided into Indigenous Africans of various ethnic groups, who make up 97% of the population, and Americo-Liberians (Descendents of African American settlers and freed Afro-Caribbean slaves) make up 3% of the population. Liberia has endured two violent civil wars in the last 15 years: the first from 1989-1997, the second from 1999-2003. More then 200,000 people are estimated to have been killed since 1989, while more than a million people were forced into exile as refugees. Liberia's civil war resulted in approximately 215,000 refugees at the end of 2001; 50 to 80% were women. Liberia has the largest percentage of refugees and internally displaced individuals in the world. The majority of the refugees lived in Côte d'Ivoire up until 2002 when the unrest and violence due to the Côte d'Ivoire conflict dramatically affected the well being of Liberian refugees and they were violently forced out of the region.[1, 2]

3

Pre-migration	During flight & refugee camps	Post-migration & resettlement
For the last decade Liberians had had little or no access to health services, exposure to infectious diseases, and low immunization rates	Malnutrition, diminished immune system, diarrheal disease, typhoid, hepatitis B, dysentery, cholera, sexually transmitted diseases	Problems and stressors of resettlement, crime, chronic conditions, parasites

Common Health Considerations

Health practitioners should be aware of the following possible medical issues among the Liberian refugees resettled in the United States:

- Sexually Transmitted Diseases
  - — HIV/AIDS:
    Statistics show an HIV/AIDS prevalence of 5.9%; the actual rate is believed to be higher.[4] HIV Type 2 is prevalent in both Liberia and Côte d'Ivoire affecting 1% of the population. While the prevalence of HIV-2 is comparatively lower than HIV-1 in most populations, given the prevalence of the disease among Liberians, health care providers are encouraged to discuss HIV-2 with their Liberian patients.
  - — Syphilis
    Preliminary results from domestic and overseas exams indicated that there is a high rate of syphilis in this population. There are also reports of cases that were not diagnosed overseas, indicating that they were either not tested or that they contracted the disease after the overseas exam.

- Communicable Diseases
  - — Tuberculosis
    Overseas exams indicate relatively high rates of tuberculosis (TB) among the Liberian refugees. Most of the cases appear to be in young adults ages 20-32. Because of relatively high rates of TB and HIV reported among Liberian refugees, and the high risk of developing TB disease once infected, the CDC has recommended that the refugees be evaluated for active TB and tested for latent TB infection (LTBI) upon arrival to the USA.
  - — Diarreheal Diseases
  - — O'nyong-nyong Fever
    In fall of 2003 there was an O'nyong-nyong fever outbreak among refugees who had been in the Nicala refugee camp.
  - — Shigellosis (bacillary dysentery)
  - — Cholera
  - — Measles
  - — Meningitis
  - — Hepatitis A, B, C, and D
  - — Typhoid and Paratyphoid Fever (or Enteric Fever)
  - — Trachoma
  - — Dengue Fever
  - — Yellow Fever
    There have been several outbreaks of Yellow Fever in Côte d'Ivoire recently
- Intestinal Parasites
  - — Ascaris
  - — Enterobius
  - — Giardia
  - — Hookworm
  - — Strongyloides
  - — Trichuris
- Non-Intestinal Parasites
  - — Filarial Parasites
  - — Guinea Worm
  - — Leishmaniasis
  - — Malaria
    Domestic health exams indicate a high number of people exposed to malaria (Approximately 4%). If any refugee should present with a febrile illness suggestive of malaria, evaluation should include an examination of thick and thin blood smears for malaria parasites.
  - — Schistosomiasis
    There have been several domestic cases of Schistosoma infections among Liberian refugees. The most common types of worms found in Africa are S. mansoni (infects liver and intestines) and S. haematobium (infects the urinary tract)
  - — Scabies (Sarcoptes scabiei)

- Female Genital Cutting/Female Genital Mutilation (FGC/FGM) is practiced by 95% of Liberian women.
  This can lead to long-term effects such as:
  - — Cysts and Abscesses
  - — Keloid scars
  - — Urinary incontinence
  - — Painful sexual intercourse
  - — Sexual dysfunction
  - — Difficulty with childbirth
- Malnutrition
  - — Marasmus
  - — Kwashiorkor
  - — Cachexia
- Chronic Conditions
  - — Hypertension
  - — Diabetes
  - — Sickle Cell Anemia
    The prevalence of the Sickle Cell gene among Liberians is estimated to be high. Sickle Cell should be explored as a possible cause for anemia.
  - — Amputations
- Oral Health
  Most refugees have not had any access to dental care and many suffer from periodontal disease, caries, gingivitis and calculus, and tooth decay.
- Mental Health
  Psychosocial resettlement concerns for Liberians can be linked to the decades of conflict and instability. High rates of violence in the refugee camps have also contributed to a decreased sense of security and well being. Many will be struggling with the after-effects of violence and physical trauma.
  - — Post Traumatic Stress Syndrome
  - — Depression
  - — Anxiety
- Recommended laboratory tests for Liberian refugees:
  - — Nutritional assessment
  - — Stool for ova and parasites
  - — Hepatitis B surface antigen
  - — Hemoglobin or hematocrit
  - — VDRL
  - — HIV
  - — PPD

Liberians make a distinction between the physical cause of a disease and the actual reason it inflicted an individual. Like many other African cultures, evil spirits and sorcery are often believed to be the causes of illness. Most Liberians opt for a combination of Western and traditional methods to treat an illness. Traditional treatments may include herbal remedies, scaring, chalking, or painting over the afflicted area, and tying of wrists, neck, or abdomen with ropes. Such practices need to be dealt with sensitively.[1, 5]

Family & Social Structure

- Preliminary information points out that refugees are 70% women and children. Children under the age of 15 make up almost 50% of the population. Initial information shows that there are broken families and multigenerational households (e.g., small number of bread earners with a large number of dependents such as small children, elderly and disabled adults).

- Liberians do not like to live alone. They live with members of their immediate and extended family. The number of people living in a typical household varies according to the family's income. The more they earn, the larger the household will be.

- It is common for men, more often in rural areas, to take on more than one wife. There is an average of four to five children per family. If a man takes more than one wife, more children will be added to his family. Women, and often older siblings, look after children. It is considered normal for children to be disciplined by people from outside of the family group. The community is seen as the "broader" family.

- Family roles are quite traditional in Liberia, with men still expected to be the main breadwinners. Men are also expected to make all the major family decisions. Attitudes are changing, but the majority of men do not consider women to be equal to men.

- Women are expected to handle all childcare and household duties. The kitchen is solely a female domain, and men are encouraged not to enter. Women's access to formal education is increasing but female literacy rates are significantly lower than the literacy rates for men.

- The elderly (usually a person aged 40 and over) are highly respected in Liberia. If there is a dispute in a family or in the community it is always the elderly who provide advice towards a solution. When no longer able to look after themselves, the elderly are cared for by their families.

- English is Liberia's official language and the main language spoken in urban areas. American English is taught in all schools due to Liberia's historical relationship to the United States. However, the commonly spoken English is a form of "pigeon" English with sentence structure, grammar, and vocabulary often markedly different from American English and there may be translation issues. Other spoken languages are Mel, Kwa, Mande, and Krahn.

Reproductive Health

- Liberians have a high fertility rate with an average of almost 7 children per woman. The number of pregnancies is exacerbated by the frequency of pregnant women still breastfeeding infants while expecting another child. This depletes the mother's nutritional status, leaves her more susceptible to disease, increases the risk of low birth weights, and leads to early weaning of older children. A high prevalence of babies with low weight is common.

- Women may reduce their food intake in order to limit the size of their baby and to prevent a difficult birth after experiencing female genital cutting/female genital mutilation.

- It is estimated that 50-60% of Liberian women experience Female Genital Cutting (FGC), also called Female Circumcision, or Female Genital Mutilation (FGM).[6] Within Liberian culture the practice of FGC is highly significant and is linked to the Sande or the women's secret society. Within this culture, women are not perceived as adults, eligible for marriage, able to join the Sande, or able to bear children unless they have had the procedure.

- The procedure is typically performed when the girls are prepubescent but may be done as early as 3 years old. There are typically two types of FGC practiced. The first is the removal of the clitoris and the labia minora but leaving the labia majora intact. The second is called Clitoridectomy, where only the clitoris is removed, leaving the labia majora and minora intact.

- Immediate or short-term issues include severe pain, shock, hemorrhage, urine retention, ulceration of the genital region and injury to adjacent tissue. The procedure is often performed as a group using the same razor blade or knife for all the girls, which could spread blood born diseases.

- Some of the long-term consequences can include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, painful sexual intercourse, sexual dysfunction, and difficulties with childbirth. New research also indicates that women who have had FGC are at increased risk of contracting HIV during intercourse.

- During the civil war, an estimated 40% of women were raped. Forced marriage, prostitution, domestic abuse and increasing risk of HIV and other sexually transmitted infections impacted all women. Women faced substantial barriers to care and few accessed preventive or curative services.

- Ritual practices such as "cleansing of African widows by having sex with a relative of the deceased husband" have led to higher STD rates among women.[7]

- In fiscal year 2005, USAID provided 85% of the commodities used for the Liberian Reproductive Health program and the fight against HIV/AIDS.[8]

Maternal and Child Health [10, 11]

- Maternal mortality is among the highest in Africa and the current maternal mortality is estimated at 780/100,000 live births. Infectious causes of death are identified in preconceptional, prenatal, and postnatal care, integrated with other reproductive health and primary care services. Causes of maternal death are multi-factorial and cannot be resolved simply by increasing the percentages of deliveries by skilled birth attendants.

- A January and March 2004 study of women residing in the refugee camp at Oru in Ogun State, Nigeria, shows how forced migration contributes to increase incidence of both communicable and non-communicable diseases in women. During the civil war, an estimated 40% of all Liberian women were raped.[9]

- Traditional Birth Attendants are an integral part of the delivery process and are respected members of society.

- There has traditionally been a preference for sons over daughters among Liberians. This often leads to adverse psychological and physical affects. There is indication of preferential treatment in the feeding and care of children based on gender.

- At two months of age, only 50 percent of children are exclusively breastfed.

- Liberia's infant and under-5 mortality rates remain among the five highest in the world. More than 15 per cent of children die before reaching their first birthday.

- Preventable diseases like malaria and measles are among the leading killers of children. Malnutrition and respiratory infections kill thousands of children each year.

- Nearly 40% of children under age five suffer from stunting as a result of malnutrition.

- Armed conflict, HIV/AIDS and other diseases have orphaned an estimated 230,000 children.

Diet and Food

- In their native country, as well as in the United States, rice is the staple food for Liberians. A typical diet consists of rice, fufu and cassava. Protein favorites include all types of smoked meat and fish, as there are no refrigerators in their countries of origin. Overall their diet was healthy until they left their native country and resettled in refugee camps. Due to their low economic status while living in refugee camps, refugees were unable to purchase specialty foods.

- During and since the civil war and the time they spent in refugee camps, malnutrition increased dramatically. Chronic malnutrition is generally a result of perinatal childhood malnutrition or prolonged periods with insufficient intake. Micronutrient deficiency is another form of malnutrition that is potentially a significant issue for most refugees. Children and women are severely affected by deficiencies in iron, vitamin A, iodine, and folate that can lead to low-birth weight, stunting, blindness, mental and developmental delay and birth defects.[12]

- The Muslim population generally does not drink alcohol. Liberians generally drink very little alcohol. They drink water, various fruit juices, cola drinks, and coconut milk.

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VII-D: BURMESE HEALTH SHEET

History & Background

Since gaining independence from Britain in 1948, Burma has been mired in decades of violence and unrest. Under two different military regimes, in power since 1962, the Burmese people have been denied any political freedoms. The Burmese civil conflict has led to the widespread laying of landmines, gross and systematic violations of human rights and various forms of forced labor. In addition, forced relocation has displaced large numbers of people from their traditional lands. The border area is essentially inaccessible to humanitarian aid organizations. The civil conflict has resulted in many refugees crossing the border into Thailand. The U.S. Committee for Refugees estimated that as many as 276,000 Burmese refugees are currently present in Thailand. Burmese have been marginalized and denied access to social services, as they have become cheap labor for Thailand. Thailand has not ratified the 1951 United Nations Convention Relating to the Status of Refugees. The refugees residing in camps or waiting to be processed into the camps are considered as "temporarily displaced". Of the Burmese refugees arriving in the United States, around 50% are Karen, 25% are ethnic Burmese, 15% are Mon, and the rest are a mix of other ethnic groups.[1, 2]

Pre-migration	During flight & refugee camps	Post-migrational & resettlement
Drug use and abuse. (Burma & Thailand are part of the golden Triangle, one of the main opium and amphetamine production areas in the world.) Injecting Drug use is linked to the HIV/AIDS epidemic in the region. Malnutrition. Lack of education.	Iron Deficiency Anemia (IDA). Micronutrient deficiencies. Adolescent girls trafficked into sex work, abducted or raped. HIV/AIDS, Hepatitis B & STD's. Malnutrition. Lack of water and sanitation. Lymphatic filariasis. Marginalized population.	Increasing susceptibility to chronic diseases. Problems and stressors of resettlement. Mental health problems. Malnutrition. Malaria.

Common Health Considerations

Health practitioners should be aware of the following possible medical issues in Burmese refugees resettled in the United States:

- Sexually Transmitted Diseases
  - — HIV/AIDS:
    The prevalence of AIDS in Burma is 1.2% while among Burmese coming from Mae Sot (location in Thailand with significant population of Burmese refugees) is 2%.
  - — Syphilis
  - — Trachoma
- Communicable Diseases
  - — Tuberculosis
    The estimated prevalence in the general Thai population is 141 cases per 100,000 but prevalence among Burmese refugees is unknown.
  - — Avian Influenza
    Avian influenza has been circulating among the poultry flocks of Thailand. If individuals show symptoms typical of influenza and are known to have traveled to areas were Avian influenza is prevalent in the past 10 days, Avian influenza may be suspected.
  - — Hepatitis
  - — Leptospirosis
  - — Measles
  - — Meliodosis
  - — Mycetoma
  - — Typhus
  - — Typhoid and paratyphoid fever (or enteric fever)
  - — Yaws

- Parasites
  - — Multi-drug resistant malaria
    Refugees from Mae Sot are at an increased risk for multi-drug resistant strains of malaria. Both falciparum and vivax malaria are known to occur in the Thai border region.
  - — Amebiasis
  - — Angiostrongyliasis
  - — Capillariasis
  - — Chikungunya
  - — Cholera
  - — Clonorchiasis
  - — Cryptococcosis
  - — Cryptosporidiosis
  - — Cysticercosis
  - — Dengue Fever
  - — Dengue Hemorrhagic Fever
  - — Filariasis
  - — Gnathostomiasis
  - — Helminthiasis
  - — Leishmaniasis
  - — Leprosy
  - — Paragonimiasis
  - — Paragonimiasis
  - — Scabies (Sarcoptes scabiei)
  - — Schistosoma
  - — Strongylodiasis
  - — Trichuriasis
  - — Trematodes
- Other
  - — Tropical Sprue
  - — Disabilities due to landmines
  - — Thalassemias
    Alpha Thalassemias is most common in Southeast Asia and China
- Oral Health
  Most refugees have not had any access to dental care and many suffer from periodontal disease, caries, gingivitis and calculus, and tooth decay.
- Mental Health
  WHO estimates that 50% of refugees suffer from mental disorders
  - — Post Traumatic Stress Disorder
  - — Depression
  - — Anxiety

Illnesses are commonly treated with changes in diet by increasing one of the six Burmese tastes (sweet, sour, hot, cold, salty, bitter). Illnesses are often attributed to spirit possession or by Koro (fear of receding genitalia that can lead to death) and are also seen as either hot or cold, and treatments are opposite foods or medicines. Touching the top of a person's head is considered insulting except in the case of a medical exam.[1]

Family & Social Structure

- Burmese culture is traditionally family and religion-oriented.
- Families are extended but among refugees and immigrants nuclear families are the norm.
- Parents are held to be sacred and one of the "five objects of worship" in Buddhism, consequently, disobedience to a parent is considered a sin.[4]
- Marriage is often arranged and arrangement involves consultation with the family astrologer to determine whether the two young people will be compatible. Initiation of adulthood begins at age nine with the "*shin-pyu*" ceremony for boys, which is followed by several weeks in a monastery; and the "*nahtwin*" ceremony for girls, which includes having the ears pierced.
- A cultural practice is the use of "*thanaka*", a pale yellow paste (from the thanaka plant) applied to the cheeks, forehead, and sometimes arms of both genders but more frequently on girls and women.
- Social class lines are strong and there is little opportunity for social mobility.
- Interactions between social equals tend to be characterized by politeness and concern for the other person.
- The Burmese term *"a-nah-dah"* expresses the Burmese cultural value of "an attitude of delicacy" expressive of a solicitousness for other people's feelings or convenience."[4]
- Burmese address people and family members using different terms. For example: U means uncle but it is also a term of respect. *U* Thant, for example, was the Secretary General of the United Nations. *Daw* is the term for aunt and is the term of respect for women, e.g., Daw Aung San Suu Kyi. *Saya* is the term for teacher, master or for the traditional healer.
- It is impolite to sit in a seat higher or at the same level as an older person.
- Pointing fingers, hands, or a foot at someone is also considered rude.[1]

Reproductive Health

- A 2001 study showed that "13% of refugee women had an unmet need for family planning, 87% of the women had knowledge of HIV/AIDS; and 30% had experienced violence—20% domestic violence and 10% violence by another perpetrator."[5]

- Unwanted pregnancies and the lack of access to contraception are major public health issues in Burma. Abortion ranks in the top ten health problems in the country.

- In 1998 and 1999 more than 200 refugee women received treatment for abortion complications in the Mae Tao clinic in Thailand.[6] Complications from abortion comprised 20% of all hospitals admissions.

- Many young Burmese women and girls use sex for survival due to the overall decline in the regional economic situation.

Maternal and Child Health

Antenatal Care

- The maternal mortality rate (MMR) was 255 /100,000, live births 147/1,000 (2004) and infant mortality rate 72/1,000 (2002).[7] One half of the deaths are due to pregnancy related reasons, often due to abortion complications. For women living in rural areas, the maternal mortality doubles. The most common cause of maternal death is hemorrhage followed by toxemia. (Maternal toxemia is associated with reduced incidence of germinal matrix hemorrhage in premature babies. It is a serious infection that can develop intravascular coagulation (DIC) and organ failure).[8]

- A third of Burmese women have five or more pregnancies.

- In rural areas prenatal and neonatal care is traditionally provided by a midwife or "let-thare". In cities, clinics and hospitals are commonly used and the value of prenatal and neonatal care is well recognized.

- For the refugees living in camps**,** this prenatal and neonatal care is not the norm. Burmese women have cultural and language barriers as well as a lack of access to appropriate material regarding reproductive health.

- The number of young women with complications due to one or more abortions is common. Furthermore, it is difficult to predict spontaneous versus induced abortions, as women are not forthcoming about induced abortions. This is most important for pregnant women who want to abort to prevent pregnancy-related deaths. Pregnant women share information regarding types of deliveries i.e. what they believe as "clean techniques" and traditional birthing practices.

- Women use a wide variety of methods to end their pregnancies, including self-medication with Western and Burmese medicines, drinking ginger and whisky, vigorous pelvic pummeling and insertion of objects into the sex organs.

- Traditional dietary restrictions, for example, during pregnancy, make prenatal nutritional counseling essential. Mothers of infants and pregnant women suffer from parasitic infections and anemia and other causes of malnutrition. Anaemic mothers die more often in childbirth.

- The history of sexual abuse among many refugee women and girls may evoke strong emotional and psychological responses to gynecological exams.

- Modern methods of family planning are acceptable if offered at the time of need and in culturally appropriate ways.

Postpartum Care

- The postpartum period is viewed as a time of susceptibility to illness as the mother's body is "cold" from blood loss. The body should be warmed with external heat as well as warm drinks and foods with "hot" properties.

- Sour and bitter foods are also taken as these are thought to reduce blood flow.[9]

- Burmese refugee women also suffer from isolation from their kin networks that assist them with child rearing and moral support.

Infants [10]

- Each year, over three million children under the age of five die from diarrhoeal diseases. This, together with other health problems, including malnutrition, schitosomiasis, ascariasis, trachoma and dracunculiasis, result from risky hygiene practices and inadequate facilities for domestic water supply, sanitation and hygiene.

- 50% of all child deaths in Burma are attributed to preventable causes.

- One in three Burmese children under three are malnourished.

Diet & Food

- Rice is the staple food for the Burmese refugees' diet, which also includes fermented fish, vegetables and meat.[11]

- There is a high prevalence of anemia in children and pregnant women.

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VII-E: BURUNDIAN HEALTH SHEET

History & Background

Like its neighbor, Rwanda, Burundi's population is comprised primarily of three ethnic groups, the Hutu (about 85%), the Tutsi (about 14%), and the Twa (1%). The region was colonized by Germany and then Belgium before Burundians achieved independence in 1962. The Tutsi, traditionally pastoralists who held political and economic power through ownership of land and cattle, led the first independent Burundian government. Ethnic tensions rose, eventually erupting in a civil war in 1971. Nearly 200,000 Burundians, almost all Hutu, were killed and many others were forced to flee the country. Since then, the Hutu have been continually repressed and ethnic fighting again broke out in 1993, following the assassination of the country's first Hutu president. In 2005, national elections put a new government in place that has a great deal of work ahead. Animosity between the groups remains intense, and Burundi's high population density makes it nearly impossible for returning refugees to find land. Burundian refugees are nearly all ethnic Hutu from rural areas, speaking Kirundi, French, and/or Swahili. Of the entire population, 96% are Christian, 2% are Muslim, and 2% have no religion. The largest Christian sect is Pentecostal. An estimated 20% can read and write in one or more languages.[1,2,5]

Pre-Migration	During flight & refugee camps	Post-migration and resettlement
Malaria, malnutrition, diarrhea, influenza, pneumonia, measles, HIV/AIDS, epilepsy, typhoid, cholera, kwashiorkor (protein deficiency), little access to health care.	Malnutrition, sexually transmitted diseases, malaria, meningitis (serotype A), tuberculosis, exposure to other infectious and parasitic diseases, respiratory diseases, insufficient food rations, rape and harassment common.	Stressors of resettlement (ESL, orientation to modern amenities, unemployment), mental health problems (including post-traumatic stress disorder), family violence, and alcoholism cases.

Common Health Considerations

Health practitioners should be aware of the following possible medical issues among the Burundian refugees resettled in the United States:

- Sexually Transmitted Diseases
  - HIV/AIDS
    Adult HIV/AIDS prevalence is about 3.5%, varying among different refugee camps.
- Communicable Diseases
  - Tuberculosis
  - Diarrheal Diseases
  - Chikungunya fever
  - Bacillary Dysentery (shigellosis)
  - Cholera
  - Measles
    Outbreak of measles in a Tanzanian refugee camp, March 2000-May2001.[16]
  - Meningococcal disease
  - Hepatitis A, B, and E
  - Pertussis (whooping cough)
  - Typhoid fever
  - Yellow fever
  - Rabies
  - Polio
  - Leprosy (Hansen's Disease)
  - Diphtheria
  - Acute Lower Respiratory Infections (ALRI)
  - Plague
  - Typhus
    Refugees are at a high risk for typhus group rickettsioses.[15]

- Intestinal Parasites
  - — Soil-Transmitted Helminthiases (A.lumbricoides, Hookworm, T.trichiura)
  - — Amoebiasis
- Non-Intestinal Parasites
  - — Malaria

    Burundi has experienced its worst malaria epidemics in the last several years, and refugees should be tested for malaria. Several cases have already been confirmed among Burundian refugees recently arriving in the United States. The CDC has requested that Burundian adults and children coming from Tanzania be preemptively treated upon arrival.
  - — Schistosomiasis (bilharziasis)
  - — Onchocerciasis (river blindness)
  - — Lymphatic Filariasis
  - — African Trypanosomiasis (sleeping sickness)
  - — Leishmaniasis
  - — Cysticercosis (tapeworm Taenia solium)
- Malnutrition
- Chronic Conditions
  - — Diabetes
  - — Sickle Cell Anemia
- Oral Health

  Most refugees have not had any access to dental care and many suffer from periodontal disease, caries, gingivitis and calculus, and tooth decay.
- Mental Health

  Psychosocial resettlement concerns for Burundians can be linked to the decades of conflict and instability. High rates of violence in the refugee camps have also contributed to a decreased sense of security and well being. Many will be struggling with the after-effects of violence and physical trauma, including rape and witnessing murders of family members and friends.
  - — Post Traumatic Stress Syndrome
  - — Depression
  - — Anxiety
- Recommended screening for Burundian refugees:
  - — Nutritional Assessment
  - — HIV
  - — Malaria
  - — Stool for ova and parasites
  - — PPD
  - — Hemoglobin or hematocrit

According to the World Bank, "Over 80% of Africans rely on traditional medicine in Africa. There are one hundred local healers for every modern health practitioner. Healers use traditional medicine to treat a wide range of infectious diseases, from cancer to HIV/AIDS." Most use a combination of Western and traditional medicines, turning to traditional healers when modern treatment is unavailable or too expensive. Bodily fluids play an important role in the concept of illness. The excessive flow or blockage of blood, saliva, urine, semen, or breast milk may be considered a cause of various symptoms. Traditional medicine often relies on herbal treatments and/or prayer as cures, and should not be discouraged unless medical reasons necessitate.[14,17,18]

Family & Social Structure

- Traditionally, Hutu were agriculturalists and Tutsi were cattle herders, although Hutu often did much of the labor. Most Hutu still work the land, and the more prestigious jobs are nearly all held by Tutsi. In extreme cases, Hutu could join the Tutsi class as a reward for an unusually honorable act, and it is possible for Tutsi to fall into the Hutu class, but movements are rare. Tutsi violence is often directed at Hutu with professional training and success.

- Women are revered for fertility, but within the family and society have a low status and are expected to obey adult males. Responsibilities include childcare, cooking, cleaning, and sometimes agricultural work, and they are rarely to be found in business or government positions. In the camps, many women have lost their husbands and become heads of their households. About 15% of refugee households are led by single women.

- Polygamy is now forbidden, but still exists to a small extent. Historically, it was used as a means of child-spacing, in which the husband turns to a different wife for sex after one wife gives birth. Some groups may also practice widow "inheritance," in which a woman becomes the wife or sexual partner of her deceased husband's brother or kin. This system ensured the safety of the widow and her children by keeping them within the clan. Health care providers should be aware of their existence and encourage safe sex habits.

- Marriages are either arranged or approved by the couple's parents. A bridewealth of livestock, cash, and/or furniture is delivered from the groom's family to the bride's, and upon marriage the bride becomes part of her husband's family. Conditions in the camps may have prevented families from obtaining the traditional bridewealth, or may have increased pressure on young girls to marry early so their families could receive a bridewealth.

- Each immediate family traditionally had its own house, with homes grouped in clusters of the extended family. Families often take on new shapes while fleeing their homes. Refugees arrive without their extended family network, and often take on children of relatives and friends.

- Sixty-five percent of households include a married couple. The average family size is five people.

- Men and women may be uncomfortable discussing sexual behavior or STIs in the presence of the opposite sex (this includes the interpreter). Additionally, adolescents may be reluctant to talk about sexuality in front of the parents, and vice versa.

- Greetings between two Burundians generally involve wishing each other large herds of cattle and some type of handshake. They may remain holding hands for several minutes and stand close while speaking.

- Deceased ancestors are viewed as powerful and influential spirits, and indigenous religions invest cattle and inanimate objects with spirits. Emphasis is placed on fate rather than free will.

- Women traditionally wear brightly colored clothing while men wear white, although Western dress is popular in urban areas.

- Elders are highly respected, but Burundians consider old age to begin at 40, a perception that may clash with American lifestyles.[1,2,4,18]

Reproductive Health

- Birth rates in the refugee camps are double Burundi's national average. Contraceptives are hardly ever available, and family planning services and information are inadequate.

- Women typically give birth at home, with the help of midwives and female relatives and friends. Little prenatal and perinatal care are available, and only 25% of births are aided by health care workers.

- Sexually transmitted infections often go untreated for long periods of time, especially in women. This increases the risk of HIV infection, infertility, and cervical cancer.

- An estimated 150,000 Burundians are living with HIV. However, only 3.6% of people ages 15-24 were able to correctly identify ways to prevent HIV transmission.

- People living with HIV/AIDS are still stigmatized, which may present obstacles to testing or treatment, with women being more highly stigmatized than men. Stigma tends to be associated with low awareness about HIV/AIDS transmission, symptoms and treatment.

- In discussing means of transmission of the HIV virus, it should be noted that tattooing, piercing, scarification, and circumcision practices can be especially dangerous if tools are not sterile.

- It is also important to remember that for many women and girls, abstinence and the negotiation of condom use are not realistic options.

- Rape and sexual violence are widespread. Although most camps offer well-organized treatment, there remains a stigma attached to rape victims that often leads to incidents going unreported.[6,7,9,18]

Maternal and Child Health

- Maternal mortality rate is 1000 per 100,000 live births per year. Infant mortality is 114 per 1000 live births per year. Infants may be underweight due to poor maternal nutrition.
- Six days after a child is born, he or she is presented to the family in a ceremony called ujusohor. The child may then be named and baptized.
- Children were traditionally breast-fed until age two or three. Children are highly valued, and taught work ethic and respect for elders at an early age.
- Almost one in five children die before their fifth birthday, mostly from malaria, measles, pneumonia, malnutrition, tuberculosis, and diarrheal diseases.
- An estimated 20,000 children under the age of 14 are living with HIV, and another 120,000 under age 17 are orphans due to AIDS.
- Family violence tends to increase during repatriation due to increased stress. [2,6,7, 10]

Diet and Food

- Burundians consider it rude to turn down food or drink when offered.
- Alcohol consumption is discouraged by the various evangelical churches in Burundi, but beer remains an integral part of many ceremonies and social interactions.
- Diets are comprised mostly of carbohydrates, including beans, cassava, corn, millet, sweet potatoes, and bananas, with only small amounts of fat or protein. Deficiencies tend to be exacerbated in refugee camps, where rations are typically beans and maize cereal. Refugees are expected to supplement rations with food from gardens and livestock, but they often have little access to resources to obtain their own food.
- Food shortages have been noted in the camps, and refugees are often expected to eat the exact same food every day, sometimes for ten years. This fact contributes to the prevalence of malnutrition, especially protein deficiency.
- It has been suggested that high birth rates in the camps are the result of families' need to increase their rations. Rations per person are the same, regardless of age, size, gender, etc. Additional children increased a family's overall rations.
- Cattle are a sign of wealth and are slaughtered only reluctantly. They are considered sacred, and several customs pertain to the treatment of cows. Most refugees have lost all their cattle by the time they reach the refugee camps.[1,2,6]

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Glossary

The following definitions are relevant to refugee health and refugee resettlement.

Adjustment of Status means the process by which certain foreign nationals in the United States apply for immigrant status. Persons may have their status changed to legal permanent resident if they are eligible to receive an immigrant visa and one is immediately available. A medical examination performed by an INS-approved civil surgeon is required as part of the application process.

Alien is a term used by the Immigration and Naturalization Service and means a person who is not a citizen or national of the United States.

Amerasian refers to certain Amerasians from Vietnam admitted to the United States as immigrants under Section 584 of the Foreign Operations, Export Financing, and Related Program Appropriations Act, 1988 (PL No.100-202) or as United States citizens, under title II of the Foreign Operations, Export Financing, and Related Program Appropriations Acts, 1989 (PL No. 100-461), 1990 (PL No. 101-167), and 1991 (PL No. 101-513).

American Council of Voluntary Agencies Form (ACVA Form) refers to the form received by the state Department of Public Health from the United States Public Health Service Quarantine Station that contains demographic and medical information on individual refugees.

Arrival Paper means the notification form received from the Quarantine Station. The paper may be an ACVA Form, Orderly Departure Program Form, Non-Indochinese Refugee Notification, or Reception and Placement Assurance Form. All contain relevant demographic information.

Asylee means a foreign national who cannot return to his or her country of origin or last residence because of persecution or the well-founded fear of persecution because of race, religion, nationality, membership in a particular social group, or political opinion, as determined by the State Department or the Immigration and Naturalization Service (INS). An asylee applies for and receives this status after entering the United States.

Centers for Disease Control and Prevention (CDC) is the federal agency responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. The Division of Quarantine is responsible for the general oversight of the medical examination process both in the United States and abroad.

Civil Surgeon means a physician approved by the Immigration and Naturalization Service district office to conduct the medical examinations of applicants for adjustment of status, or other aliens referred by the Immigration and Naturalization Service.

Class A Condition means an excludable medical condition (e.g., infectious tuberculosis, HIV infection, physical or mental disorder with associated violence that may pose a threat, drug abuse or addiction) diagnosed in a refugee during the overseas medical examination. Class A conditions require approved waivers for United States entry and require immediate follow-up.

Class B Condition means a physical or mental abnormality, disease, or disability serious in degree or permanent in nature amounting to a substantial departure from normal well-being diagnosed during the overseas medical examination. Class B designations indicate a need for follow-up soon after arrival in the United States by appropriate medical personnel.

Cuban/Haitian Entrant means a person who is granted parole status or special status under the United States immigration laws for Cubans and Haitians.

Date of Entry means the date the refugee entered the United States. For Cubans and Haitians, this is the date entrance status is granted.

Department of Justice is the federal agency that enforces federal laws. The Immigration and Naturalization Service is part of the Department of Justice and is responsible for enforcing the Immigration and Nationality Act.

Department of State is the federal agency responsible for international policies, programs and activities of the United States. The Bureau of Population, Refugees, and Migration has the responsibility of formulating policies on population, refugees, and migration, and for administering United States refugee assistance and admissions programs.

Health Screening means the comprehensive assessment of newly arrived refugees organized and overseen by the Department of Health that includes:
- Follow-up of conditions identified overseas;
- Evaluation and diagnostic services to determine health status and identify health problems;
- Referral for follow-up of health problems identified;
- Education/orientation to local health care services;
- Linkage with primary health care services.

I-94 is the Immigration and Naturalization Service document that records each non-permanent resident alien's arrival in, and departure from, the United States. It identifies the period of time for which the alien is admitted and the alien's immigration status.

Immigrant means an individual admitted to the United States as a lawful permanent resident. They may be issued immigrant visas by the Department of State overseas or adjusted to permanent resident status by the Immigration and Naturalization Service in the United States.

Immigration and Nationality Act (INA) is the Act that, along with other immigration laws, treaties, and conventions of the United States, relates to the immigration, temporary admission, naturalization, or removal of aliens.

Immigration and Naturalization Service (INS) is the federal agency within the Department of Justice that administers immigration law.

International Organization for Migration (IOM) is the intergovernmental body based in Switzerland that manages refugee movements to the United States.

IOM Bag means the bag issued to refugees at the time of travel in order to carry medical and other documents, including the OF-157, immunization records and overseas chest x-rays.

Match Grant means a public/private partnership agreement between a VOLAG and the Department of State under which refugee resettlement costs are shared between the government and a community. VOLAGS that resettle refugees pursuant to Match Grants are responsible for cash and in-kind support for refugees beyond the normal 30 days in a Reception and Placement Agreement.

Material Support means providing anything of value to a terrorist organization, including but not limited to: weapons, money, personnel, training, expert advice, and assistance.

Nonimmigrant means a foreign national who seeks temporary entry to the United States for a specific purpose. Included in this category are persons on student, business or tourist visas. Although refugees, parolees and other specific categories of arrivals are processed as non-immigrants upon arrival to the United States, these classes are not included in nonimmigrant admission data.

OF-157 means the Department of State Optional Form 157 "Medical Examination of Applicants for United States Visas". This form is in the possession of the arriving refugee and contains all findings from the overseas medical examination.

Office of Refugee Resettlement (ORR) is the federal office within the Department of Health and Human Services that provides for the resettlement of refugees arriving in the U.S.

Orderly Departure Program (ODP) means the program between the United Nations High Commission for Refugees (UNHCR) and Vietnam that established a legal emigration program for those seeking family reunification, or those of special interest to resettlement countries (e.g., former political detainees, Amerasians). The program was established to provide an alternative to the dangerous boat departures.

Parolee means an alien who has been given permission to enter the United States under emergency conditions or when that alien's entry is considered to be in the public interest.

Port of Entry means any location in the United States or its territories that is designated as a port of entry for aliens and United States citizens. Refugees are (generally) limited to entering the country through those ports of entry with staffed Quarantine Stations.

Quarantine Station means the station at a major port of entry that is charged with preventing the importation and spread of communicable disease into the United States. Quarantine officers inspect arriving aliens and medical documents and forward copies of documents to appropriate health authorities in the resettlement location. Refugee arrivals are limited to the seven ports of entry where CDC has staff (Atlanta, Chicago, Honolulu, Los Angeles, Miami, New York City, San Francisco, and Seattle).

Refugee means a foreign national who cannot return to his or her country of origin or last residence because of persecution or the well-founded fear of persecution because of race, religion, nationality, membership in a particular social group, or political opinion, as determined by the Department of State or the Immigration and Naturalization Service (INS). A refugee receives this status prior to entering the United States. [The term "refugee" is defined in Section 101(a)(42) of the Immigration and Nationality Act (8 USC 1101(a)(42)).] For the purposes of the Health Assessment Program, the term "refugee" encompasses asylees as well as Cuban or Haitian Entrants. Applicants for asylum are not included except Cuban and Haitian applicants eligible under section 501 of the Refugee Education Assistance Act of 1980.

Refugee Act of 1980 refers to Public Law 96-212, enacted in 1980. The Refugee Act established a comprehensive refugee resettlement and assistance policy. It provides mechanisms for setting annual level of admissions to the United States, authorizing refugee admissions in emergency situations, and authorized, for the first time, federal assistance to resettle refugees in the United States on a uniform basis, regardless of their country of origin. Refugee Cash Assistance (RCA) means the program of temporary cash assistance for refugees not eligible for TANF or SSI. It is funded through ORR and the period of funding is time limited by ORR, depending on availability of funds. [In 1990, the period of eligibility was set at 8 months from the date of entry.]

Refugee Medical Assistance (RMA) means the program of temporary medical assistance for refugees not eligible for Medicaid. It is funded through ORR.

Resettlement Agency (VOLAG) means a national voluntary agency, or a local affiliate or subcontractor of a national voluntary agency, that has entered into a grant, contract, or cooperative agreement with the United States Department of State or other appropriate federal agency to provide for the reception and initial placement of refugees in the United States.

Secondary Migrant means a refugee who initially settles elsewhere in the United States and subsequently moves to Rhode Island or vice versa.

Sponsor means the person or organization that assists an applicant in their admission to the United States.

Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency, comprised of three centers that carry out the agency's mission of providing substance abuse and mental health services. The Refugee Mental Health Program is within the Center for Mental Health Services.

Supplemental Security Income (SSI) means the federally funded cash assistance program for low income persons who are aged [65 years or older], blind or disabled and qualify for eligibility. Eligibility is contingent on income and provides a guaranteed minimum income based on need. Refugees, asylees, entrants, parolees, and certain other aliens may qualify for this program.

Temporary Assistance to Needy Families (TANF) means the federal-state program that provides assistance to families with dependent children who meet certain financial specifications. Refugees, asylees and entrants are exempted from the bar to receiving TANF assistance during the first five years of United States residence that is applied to qualified aliens.

Unaccompanied Minor means refugee children under the age of 18 years arrive in the United States without a guardian and are placed in foster care.

United Nations High Commission for Refugees (UNHCR) is the United Nations agency given the mandate to lead and coordinate international action for the worldwide protection of refugees and the resolution of refugee problems.

Visa Medical Examination or Overseas Medical Examination means the physical and mental examination immigrants and refugees coming to the United States complete as part of the visa application process. The purpose of the visa medical examination is to identify the presence or absence of certain disorders that could result in exclusion from the United States under the provisions of the Immigration and Nationality Act.

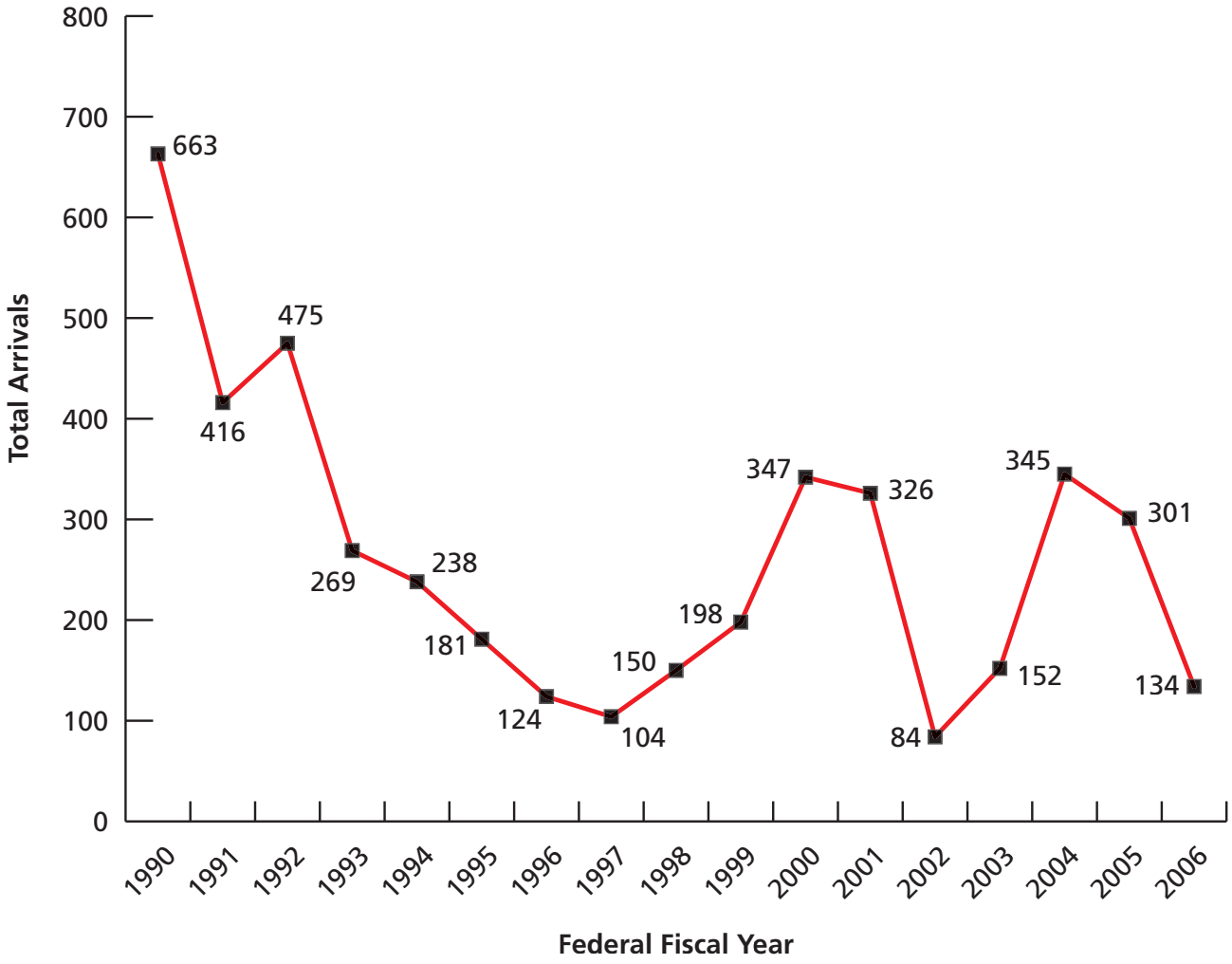
VOLAG means a national voluntary agency or a local affiliate responsible for initial refugee resettlement.

Appendices

Appendix A

New Refugee Arrivals to Rhode Island

(RI Department of Human Services)



Appendix B

Excludable Conditions for Entry into the United States

Refugees must obtain a waiver of admissibility if any of these conditions are documented in their medical record or identified during overseas examination.

Class A Conditions

- TB active, infectious
- Syphilis, untreated
- Chancroid, untreated
- Gonorrhea, untreated
- Granuloma inguinale, untreated
- Lymphogranuloma venereum, untreated
- Human immunodeficiency virus (HIV)
- Hansen's disease, lepromatous or multibacillary
- Addiction or abuse of specific substance* without harmful behavior
- Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur.

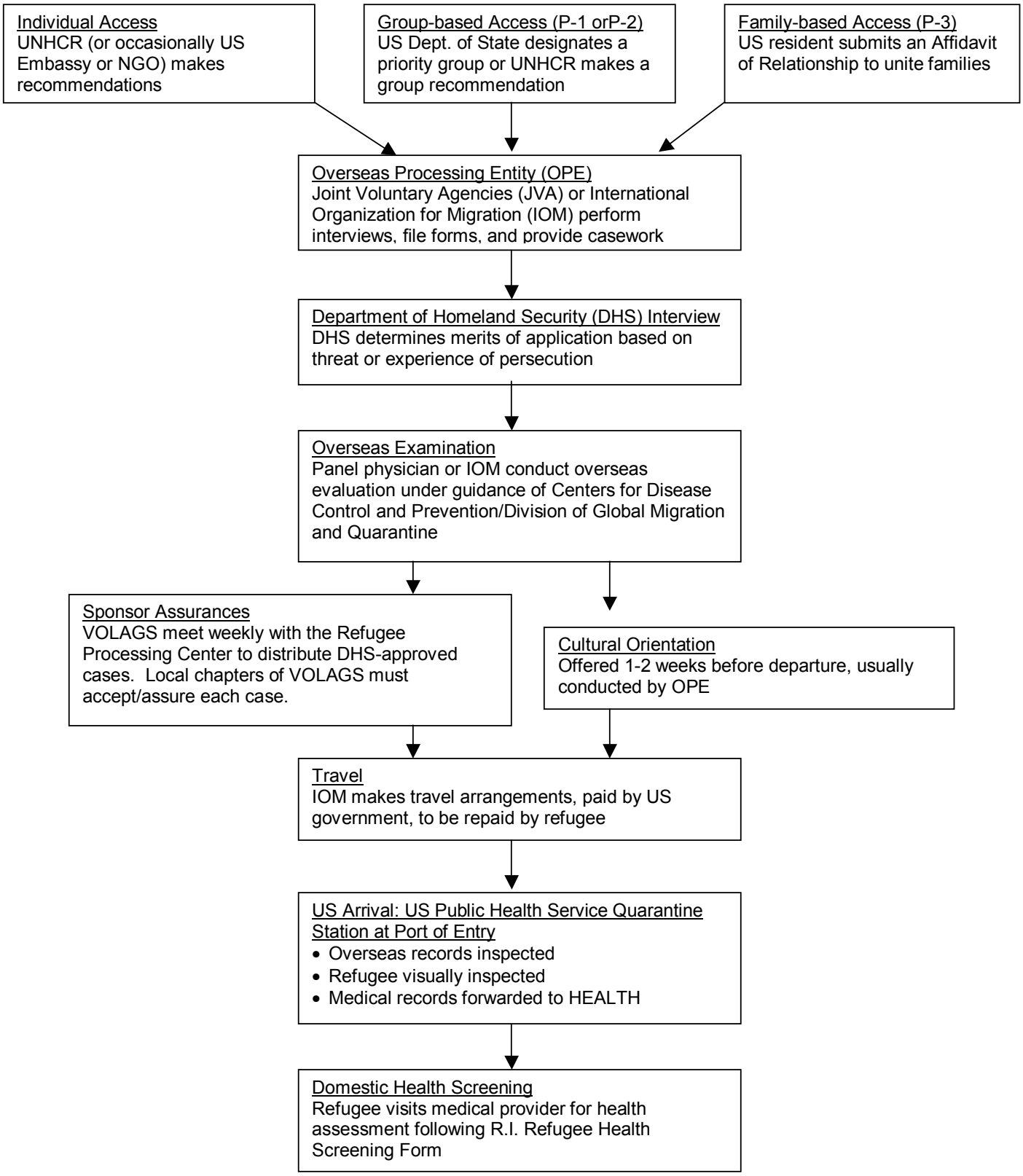
Class B Conditions

- TB, active, noninfectious
- TB, inactive
- Syphilis, treated within last year
- Other sexually transmitted infections, treated within last year
- Current pregnancy
- Hansen's disease, prior treatment
- Hansen's disease, tuberculoid, borderline, or paucibacillary
- Sustained, full remission of addiction or abuse of specific substances*
- Any physical or mental disorder (excluding addiction or abuse of specific substance* but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur
- Other _____

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

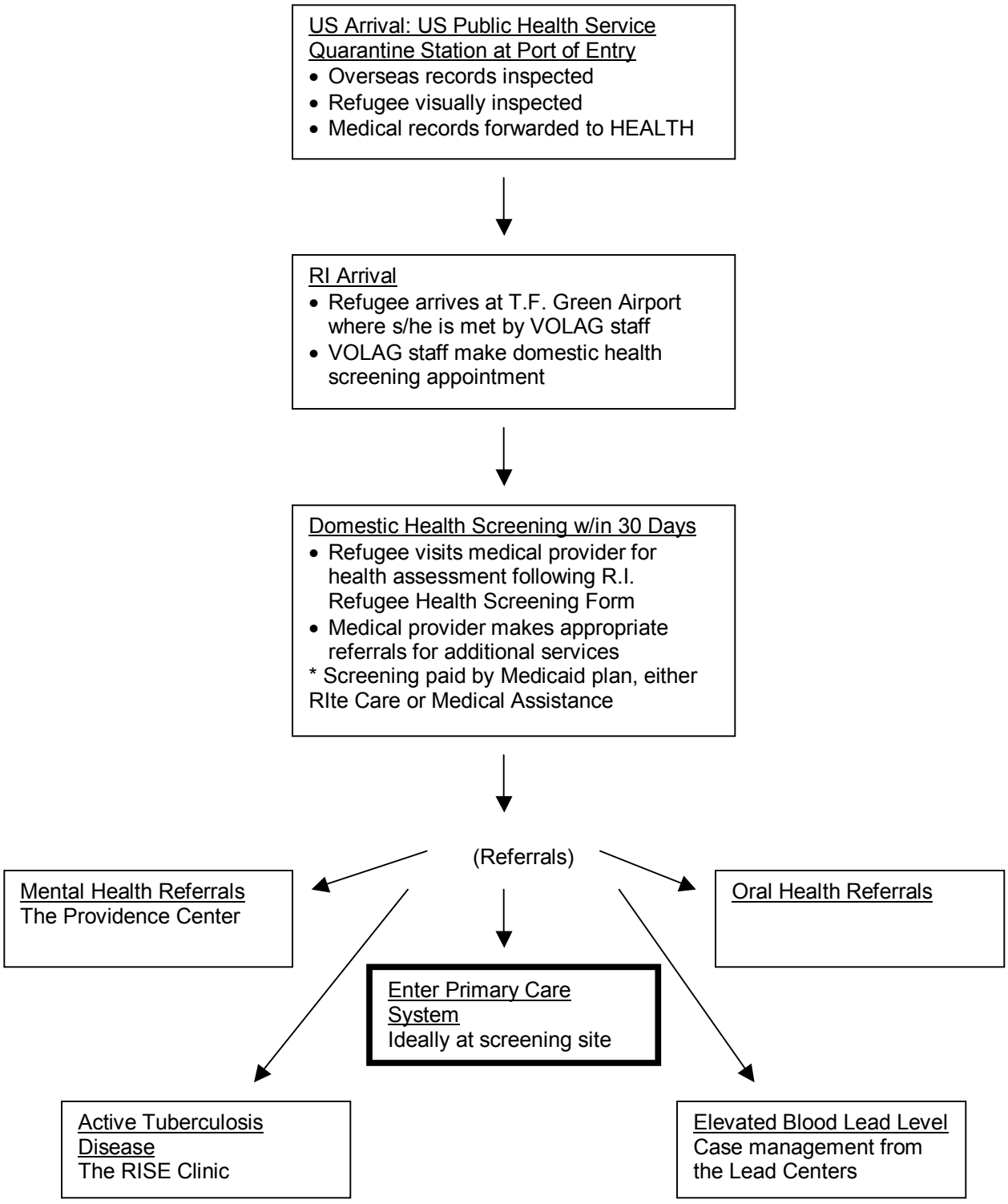
Appendix C

International Refugee Resettlement Process



Appendix D

R.I. Refugee Health Process: An Overview



Appendix E

Instructions for Completing RI Refugee Health Screening Form

Introduction:
The RI Department of Health has adopted the department of State and Office of Refugee Resettlement recommendations that newly arriving refugees have a health screening within 30 days of entry into the US. Refugees may be at high risk for various communicable, chronic, and psychological conditions. Screening incoming refugee populations benefits the individual refugee by quickly identifying health needs and allowing for prompt referral into appropriate health care services. The collection of refugee health screening data is useful in order to document trends and needs, identify resources, and develop systems to support such needs.

Instructions:
Please complete the Refugee Health Screening Form within 30 days of US arrival for each newly arrived refugee. Refugees may come to your clinic/office with a refugee health packet that will be useful in filling out the RI Refugee Health Assessment Form. The refugee health packet may include:

- Reception and Placement Program Assurance Form (Assurance form)
- Medical Examination for Immigrant or Refugee Applicant (Medical Examination form, DS-2053)
- Vaccination Documentation worksheet
- Other medical assessment forms

Mail or fax the completed form to:
Refugee Health Program
Rhode Island Department of Health
3 Capitol Hill, Room 407
Providence, RI 02908

Fax: 401-222-4392
Ph: 401-222-2901

Below, please find field definitions, in the event clarification is needed.

Provider Information	
Demographic fields	Screening physician; facility name, address, and phone number (stamp if appropriate).

Patient Information	
Unique ID	**Leave blank.** To be entered at HEALTH.
Demographic fields	Self-explanatory.
Date of US arrival	Refer to refugee health packet documents, if possible. The Assurance form, usually the front page, will have a date stamped by the receiving quarantine station.
Country of origin	On Assurance form, it is "POB" (place of birth); on Medical Examination form, it is "Birthplace" country.
Country of exit	On Assurance form, it is "Present location" at top of form; on Medical Examination form, it is "Present country of residence."
Language spoken & read	Per refugee.
Interpreter provided	Check Yes or No.
Ethnicity and Race	Per refugee selection. Refer to HEALTH Policy on Maintaining, Collecting, and Presenting Data on Race and Ethnicity. (http://www.health.ri.gov/chic/statistics/data policy guide.pdf).
Volag	Refers to the voluntary resettlement agency supporting the refugee. Most refugees have an assigned volag. On Assurance form, it is listed as "Affiliate" on the left side under the list of refugee names. • International Institute of RI • Diocese of Providence (may be listed as "Immigration and Refugee Services," it is the VOLAG located on 184 Broad St, Providence)

Instructions for Completing RI Refugee Health Screening Form

Immunizations
Review overseas medical exam (DS-2053) if available and document immunization dates.
For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease.
For all other immunizations, update series, or begin primary series if no immunization dates are found.
All vaccines may be given at the same time in different sites of the body.
Questions? Refer to the current adult and childhood immunization schedules. http://www.cdc.gov/nip/home-hcp.htm

Tuberculosis Screening	
PPD (Mantoux) date planted/read	Date PPD planted/read at RI clinic/office.
PPD size (mm)	Size in millimeters across arm.
PPD interpretation (select one):	Positive or Negative: Based on current CDC guidelines on PPD classifications. http://www.cdc.gov/nchstp/tb/pubs/PDF/1376.pdf Table 8.
Hx of BCG?	Yes, No, or Unknown: Has the refugee had a BCG vaccination? PPD should be planted and read regardless of BCG vaccination history.
Date of BCG	If so, date of BCG vaccination, if known.
CXR date/findings	Chest X-ray date and results (if CXR indicated).
TB therapy	If TB therapy indicated (by PPD and/or CXR results), select option which best describes therapy for suspect/active or latent TB infection (LTBI). For patients referred for treatment, indicate referral clinic (e.g. RISE Clinic). **Note:** Suspect and active TB are reportable to the RI Department of Health within 48 hours of suspicion or immediately upon confirmation. Call 401-222-2577. (LTBI is not reportable in RI.)

Women	
LMP	Date of start of most recent menstrual period.
Pregnant?	Yes, No, Unknown: Indicate current pregnancy status.
# Pregnancies	Total number of pregnancies.
Premature births	Includes live and non-live births
Live births	Number of live births.
Living children	Current number of living children

Other Screening	
Hep B	Date and results of HBsAg, Anti-HBs, Anti-HBc
Hep C	Date and results of hepatitis C test.
HIV	It is recommended by the Office of Refugee Resettlement that refugees be screened for HIV. **Check Yes or No regarding HIV screening, and enter date if HIV screened. Do not enter result due to RI state HIV confidentiality laws.** Enter results in your patient chart. Positive HIV tests are reportable.
VDRL/RPR	Date and results of syphilis test.
CBC with differential	Date and results of CBC.
Hgb/Hct	Hemoglobin/hematocrit date and results.

Instructions for Completing RI Refugee Health Screening Form

Blood lead	**For refugee children under 16 y/o (children 9-192 months old), date and results of venous lead test.** Lead Screening and Referral Guidelines for Refugees: http://www.health.ri.gov/lead/family/Final_Screening_Guidelines.pdf State screening and referral guidelines: http://www.health.ri.gov/lead/family/lead_poster.pdf
Malaria	Malaria screening (thick blood smears) if history or symptoms (e.g. febrile illness) are consistent with malaria.
U/A	Urinalysis.
Ova and Parasites	Screen stool for all ova and parasites; check those that are positive. (One stool sample for screening; however, those with symptoms of parasitic disease should provide three samples.) **Presumptively treat Somali Bantu and Sudanese refugees for schistosomiasis and strongyloidiasis per the CDC recommendations** at http://www.cdc.gov/ncidod/dq/pdf/Overseas_Domestic_Pres_Tx_Rec_Sudanese_6-13-05.pdf (Somali Bantu) and http://www.cdc.gov/ncidod/dq/pdf/Lost%20Boys%20and%20Girls%20Presumptive%20Treatment%20Recommendations.pdf (Sudanese).
Other disease screening	Based on background and physical presentation: Sickle cell, Thalassemia, and Tay Sachs are recommended, as well as any others deemed appropriate by physician.

Physical Exam / Review of Systems	
Check each area evaluated as Normal (N) or Abnormal (Ab) and document physical exam observations.	
Head circumference (<5 years)	For children under 5 years, document head circumference.
BMI	Body Mass Index: Calculate BMI in standard measurements (inches/pounds). BMI = (lb./in.^{2})*703. BMI calculators available on internet. (http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm)

Mental Health
If you check columns (2), (3), or (4) for "Thoughts of ending life", please refer. Also, if you check more than three rows in columns (3) and/or (4), please refer.

Medical History	
Document medical history components.	
Complementary and alternative medicines	Herbs, root medicines, acupuncture, etc.
Injuries/accidents History of trauma	Depending on patient history, be aware of possibility of war/violence/torture as source of injury or trauma.

Referrals
Indicate any referrals made as a result of initial refugee health screening visit. All refugees should be referred to a primary care provider.

**** Please sign, date, and print name on the form upon completion of health screening.***

R.I. Refugee Health Screening Form

Please complete health screening within 30 days of U.S. arrival.
Upon completion, mail or fax to:
Refugee Health Program
Rhode Island Department of Health
3 Capitol Hill, Room 407
Providence, RI 02908
Phone: (401) 222-2901 Fax: (401) 222-4392

Provider Information
Physician's Name:
Facility:
Address:
Phone:
Fax:
Email:

Patient Information		**Unique ID:**
Last Name:	Street Address:	Date of U.S. Arrival:
First Name:		Country of Origin:
Middle Name:		Country of Exit:
Gender: ☐ M ☐ F	City, Zip:	Language Spoken:
DOB:	Phone:	Language Read:
Parent/Guardian:	Email:	Interpreter Provided: ☐Y ☐N
Ethnicity: ☐Hispanic ☐Non-Hispanic	Race: ☐White ☐Asian ☐Native Hawaiian/ Pacific Islander ☐African American/Black ☐American Indian/Alaskan Native	
VOLAG (check resettlement agency): ☐International Institute of RI ☐Diocese of Providence		

Immunization Record: Review overseas medical exam (DS-2053) if available and document immunization dates. For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations, update series, or begin primary series if no immunization dates are found. All vaccines may be given at the same time in different sites of the body.

Immunizations	Completed Series or Fully Immune (Check if yes or write date of lab test if immune)	**Immunization Dates**				Check if Not Appropriate Age OR Not Flu Season	Check if Contra-indication
		mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy		
Diphtheria/Tetanus/Pertussis (DTP/DT)							
Tetanus-Diphtheria (Td)							
Polio (IPV/OPV)							
Measles (or MR or MMR)							
Mumps (or MMR)							
Rubella (or MR or MMR)							
Haemophilus influenzae type b (Hib)							
Hepatitis B							
Varicella (VZV)							
Pneumococcal							
Influenza							

Tuberculosis Screening				
PPD/Mantoux Regardless of BCG Hx		**CXR (if indicated)**		**TB Therapy (if indicated)**
Date planted		Date		☐ Referred for treatment of suspect or active TB to _____ (reportable)
Date read		Findings		☐ Referred for LTBI treatment to _____
PPD size (mm)				☐ To treat for LTBI on site
PPD interpretation	☐ Pos ☐ Neg			☐ No referral for LTBI treatment: ☐ Treated overseas ☐ Refused ☐ Pregnancy ☐ Other:
Hx of BCG?	☐Y ☐N ☐U			
Date of BCG				

Women					
LMP:	Pregnant ☐Y ☐N ☐U	# Pregnancies:	Premature births:	Live births:	Living Children:

-Please turn page to continue assessment-

Other Screening					
Date:	Hep B:	Date:	Blood lead **(<17 yrs)** venous (µg/dL):	Date:	VDRL/RPR:
	HbsAg:		Hep C:		Other STIs:
	Anti-HBs:		Malaria (if symptomatic):		CBC w/differential:
	Anti-HBc:		U/A:		Hgb/Hct:
	O & P: *Screen for all, check respective parasite(s) if positive or* ☐ None Identified ☐ Ascaris ☐ Giardia ☐ Strongyloidiasis Giardia Fab: ☐neg ☐pos ☐ Blastocystis ☐ H. nana ☐ Trichuris Cryptosporidium Fab: ☐neg ☐pos ☐ E. histolytica ☐ Hookworm ☐ Schistosomiasis ☐ Other: _____				
	Other: *Sickle Cell, Thalassemia, and Tay Sachs recommended based on background and physical presentation*				

Physical Exam / Review of Systems	
Height (or length if <5yrs) (in.):	Head circumference if <5 yrs. (in.):
Weight (lbs.):	Blood pressure:
☐N ☐Ab Vision	☐N ☐Ab Lymph nodes
☐N ☐Ab Hearing	☐N ☐Ab Cardiovascular
☐N ☐Ab ENT	☐N ☐Ab Breasts
☐N ☐Ab Oral/Dental	☐N ☐Ab Abdomen
☐N ☐Ab Lungs	☐N ☐Ab Skin
☐N ☐Ab Reproductive System	☐N ☐Ab Musculoskeletal
☐N ☐Ab Colorectal	☐N ☐Ab Other
☐N ☐Ab Neurological	
Medical Conditions Requiring Follow-up as Noted in Refugee Medical Packet (Forms DS-2053, DS-3024, DS-3026):	

Medical History	
Allergies:	Surgery:
Current Medication:	Recent Illness in Family:
Complementary and Alternative Medicines:	Medical Problems:
History of Trauma/Injury/Accident:	Childhood Diseases:

Mental Health *excerpts from Hopkins Symptom Checklist*	Not at all (1)	A little (2)	Quite a bit (3)	Extremely (4)
Thoughts of ending life				
Spells of terror or panic/ Suddenly scared for no reason				
Crying easily				
Not being able to sleep				
Lost of appetite				
Faintness, dizziness or weakness				
Feeling low in energy, slowed down				
Feeling restless, cannot sit still				
Feeling hopeless about the future				
Feeling lonely				
Headaches				

Referrals	
Primary Care:	Oral:
Mental Health:	Hearing:
OB/GYN:	Vision:
WIC:	Other:

Comments:

Examiner's Signature_____ **Examiner's Name (Printed)**_____ **Date**_____

Appendix F

Health and Social Service Providers

State Agencies

As with all residents of Rhode Island, the R. I. Department of Health and R. I. Department of Human Services administer programs that impact refugees.

Within the Department of Health, the Office of Minority Health, the Refugee Health Program, the Childhood Lead Poisoning Prevention Program, the Office of HIV/AIDS and viral Hepatitis, the Immunization Program, and the Women, Infants and Children Program (WIC) all contribute to the health services available for refugees.

Maria-Luisa Vallejo, Refugee Health Coordinator (401) 222-7638

Within the Department of Human Services (DHS), the Food Stamp, RIte Care, and medical assistance programs are available to refugees.

Rhode Island Department of Human Services, Division of Management Services
Gail Dunphy, State Coordinator of Refugee Resettlement
(401) 462-3375

Resettlement Agencies

Two resettlement agencies, also known as VOLAGS, operate in Rhode Island. They are the Diocese of Providence and the International Institute of Rhode Island. Each of these resettlement agencies is a local affiliate of a national organization that operates resettlement programs in other states as well. The Rhode Island Department of Human Services is the single state agency responsible for refugee resettlement and employs the State Coordinator of Refugee Resettlement, Gail Dunphy, to administer the state's contracts with the resettlement agencies for reception and placement services.

Diocese of Providence, Catholic Social Services
Stella Carrera, Immigration & Refugee Services Coordinator
(401) 421-7833
Toua Kue, Case Manager
(401) 421-7833, ext. 131

International Institute of Rhode Island
Baha Sadr, Director of Refugee Resettlement
(401) 784-8611

Screening Sites

Below are some of the sites providing refugee health assessment services. Tuberculosis screening and immunizations are available at most of the sites.

Allen Berry Health & Dental Center
202 Prairie Ave. Providence, RI 02905
(401) 444-0570

Capitol Hill Health & Dental Center
40 Candace, Providence, RI 02908
(401) 444-0550

Central Health Center
234 Cranston St., Providence, RI 02907
(401) 444-0580

The Family Van, Women & Infants' Hospital
Mary Falvey, RN
101 Dudley St., Providence, RI 02905
(401) 277-3629

Fox Point Health Center
550 Wickenden, Providence, RI 02903
(401) 444-0530

Hasbro Children's Hospital
Pediatrics
Adam Pallant, MD
593 Eddy St., Providence, RI 02903
(401) 444-6072

Hasbro Children's Hospital
Pediatric Infectious Diseases
Emily Lutterloh, MD
593 Eddy St., Providence, RI 02903
(401) 444-8360

The Miriam Hospital
Immunology Clinic
Susan Cu-Uvin, MD
164 Summit Ave., Providence, RI 02906
(401) 793-2928

Olneyville Health Center
100 Curtis, Providence, RI 02909
(401) 444-0540

Providence Community Health Center, Inc.
Mary Jean Francis, RN
375 Allens Ave., Providence, RI 02905
(401) 444-0400

Rhode Island Hospital
Adult Primary Care Clinic
Mark Fagan, MD
593 Eddy St. Providence, RI 02903
(401) 444-4741

RISE Clinic (TB Medical Clinic), The Miriam Hospital
Jane Carter, MD
14 Third Street, Providence, RI, 02906
(401) 793-2427

St. Joseph's Hospital
21 Peace St., Providence, RI 02907
(401) 456-4020

Women & Infants' Hospital
Patrick Sweeney, MD
101 Dudley St., Providence, RI 02905
(401) 274-1122, ext. 2721

Mental Health and Social Service Providers

In addition to state agencies and medical providers, mental health and social service providers in the community also collaborate to provide services to refugees.

AIDS Care Ocean State
18 Parkis Avenue, Providence, RI 02907
(401) 521-3603

AIDS Project Rhode Island
232 West Exchange Street, Providence, RI 02903
(401) 831-5522

Family Service of Rhode Island
55 Hope Street, Providence, RI 02906
(401) 331-1350

The Providence Center
530 North Main St., Providence, RI 02904
(401) 276-4020

Appendix G

CLAS Standards

http://www.omhr.gov/omh/programs/2pgprograms/finalreport.pdf

CLAS Standards written in italics are mandates. (#4 - #7)

National Standards for culturally and Linguistically Appropriate Services (CLAS) in Health Care
The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide and facilitate required and recommended practices related to culturally and linguistic appropriate health services".

Standard 1 – Culturally Competent Health Care (guideline)
Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language

Standard 2 – Staff diversity (guideline)
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representatives of the demographic characteristics of the service area

Standard 3 – Staff education and training (guideline)
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4 – Qualified language assistance services (mandate)
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5 – Notices to patients/consumers of the right to language assistance services (mandate)
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6 – Qualifications for bilingual and interpreter services (mandate)
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7 – Translated materials (mandate)
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8 – Organizational framework for cultural competence (guideline)
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9 – Organizational self-assessment (guideline and recommendation)
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.

Standard 10 – Collection of data on individual patients/consumers (guideline)
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11 – Collection of data on communities (guideline)
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12 – Community partnerships for CLAS (guideline)
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13 – Complaint and grievance resolution (guideline)
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14 – Information for the public (recommendation)
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Appendix H

Web Resources

General Resources

Centers for Disease Prevention and Control
www.cdc.gov
http://wonder.cdc.gov/wonder/prevguid/m00380078/m0038078.asp.
Targeted testing and treatment:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm
Fact sheets: Treatment of LTBI:
http://www.cdc.gov/nchstp/tb/pubs/tbfactsheets/25011.htm
Revised recommendations against the use of Rofampin and Pyrazinamide for
for treatment of LTBI:
http://www.cdc.gov/mmwr/PDF/wk/mm5231.pdf or
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5231a4.htm
Broader guidance on diagnosing and treating TB:
http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf or
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm
Department of Health & Human Services Office of International and Refugee
Health
http://www.globalhealth.gov/
National Institutes of Health MEDLINE
www.ins.usdoj.gov/graphics/glossary.htm
Florida Department of Children and Families, Glossary of Refugee Program
and Immigration Related Terms
www.dcf.hcsys.com/
Refugee Health Program, Office of Minority Health
Carrie.Bridges@health.ri.gov
Word Health Organization's Web site:
http://www.who.int/inf-fs/en/fact241.html
Is there a role for traditional medicine in basic health services in Africa?
Van der Geest S.
http://www.ingentaconnect.cm/content/bsc/tmih/1977/00000002/00000009/a 00112
FUNU
http://gongocookbook.com/c0042.html
Immigration and Naturalization Service Glossary and Acronyms
http://www.nlm.nih.gov/medlineplus/medlineplus.htm
Central Intelligence Agency (2001). *World Factbook 2002*. Author. Accessed 12/14/2002.
http://www.cia.gov/cia/publications/factbook/geos/bm.html

Somali Bantu Health Sheet

Refugee Health~Immigrant Health Web site **http://www3.baylor.edu/~Charles_Kemp/africa.htm**.
Massachusetts Refugee and Immigrant Health Program
http://www.mass.gov/dph/cdc/rhip/wwwrihp.htm
Proceedings of the Nutrition Society (*Meeting the challenges of micronutrient deficiencies in emergency- affected populations*) http://saturn.bids.ac.uk/cgibin/ds_deliver/1/u/d/ISIS/21236223.1/cabi/pns/2002/00000061/
UNICEF at work in Somalia
http://www/unicef.org
CHILDBIRTH AND DISASTERS DISCUSSED IN THIS MONTH'S ISSUE OF JORNAL OF MIDWIFERY & WOMEN'S HEALTH , the Journal of Midwifery and Women's Health (JMWH), Index Medicus
http://www.jmwh.org
Voices of the Somali Community
http://ethnomed.org
Maternal Health in Africa
http://www.ifrc.or/WHAT/health/arch/fact/Fmathlth.htm

Hmong Health Sheet

Health Information
http://health.csohio.edu/healthculture/culture/hmong/hmonghealth.htm
Cultural Diversity in Health
http://www.diversityinhealth.com/regions/asia/hmong.htm
Nyo dua hli- 30 days confinement: traditions and changed childbearing
Beliefs and practices among Hmong women, Pranee Liamputtong Rice, PhD, 2003
http://www.sciencedirect.com
Hmong Shamanism. Animist spiritual healing. Plotnikiff GA, Numrich C, Wu C. Yand D, Xiong P.
http://www.ncvbi.nlm.nih.gov
Food preferences, beliefs, and practices of Southeast Asian refugees.
Story M, Harris LJ.
Hmong cultural practices and beliefs: The postpartum period. Jambunathan J.
http://www.ncbi.nlm.nih.gov
Asian and Pacific Islander American Health Forum. 2003
www.apiahf.org
Southeast Asia Resource Action Center (SEARAC)
Hmong National Development, Inc.
Http://www.hndlink.org
Ethnic Specific Health Care Beliefs and Practices
http://www.baylor.edu/~Charles_Kemp/asian_health.html
Southeast Asia –focus on the Hmong
http://www.minneapolisfoundation.org
Chapter 10. Assessment of reproductive health care needs
http://www.who

Liberian Health Sheet

World Health Organization
http://www.who.int/inf-fs/en/fact241.html.
World Health Organization, Regional Office for South-East Asia
http://w3.whosea.org/EN/Section313/Section1525_6897
Centers for Disease Control and Prevention (CDC)
http://wonder.cdc.gov/wonder/prevguid/m0038078/m0038078.asp.
Activity Data Sheet (AFR Regional Overview) –Liberia Overview-
http://www.usaid.gov/pubs/cbj2002/afr/1r/669-003.html
War in Liberia Highlights Health Threats to Refugees
http://www.migrationinformation.org/Feature/display.cfm?id=151
A guide to Liberian cultural and social norms
http://liberianpeople.tripod.com
Liberia –Between two worlds
http://www.courierpostonline.com/Liberia/lib1104s.html
Mental Health Policy Development in Africa
O Gureje & A. Alem
The socio-cultural contexts of sexually transmitted diseases in Africa
Implications for health education programmes
Meyer-Weitz P. Reddy W. Weijts B. Van Den Borne G. Kok http://journalsonline.tandf.co.uk/app/home/contribution.asp?wasp=da5d5eaba785478db91
La Franière, S. (2005). *AIDS now compels Africa to challenge widow's cleansing.* New York Times. Retrieve 5/11/2005 from:
http://www.nytimes.com/2005/05/11international/africa/11malawi.html

Burmese Health Sheet

Reproductive health services for Burmese refugees on the Thai-Burmese Border http://www.kit.nl/ils/exchange_content/html/2000_2_reproductive_health_ser.asp
Women's Commission for refugee women & children
http://www.womenscommission.org/reports/th_00.shtml
A Public Health Problem in Myanmar, Reproductive Health Matters
www.hsph.harvard.edu/grhf-asia/suchana/0000/rh141.html
Online Burma/Myanmar Library
http://www.burmalibrary.org/sho.php?cat=1638&lo=d&sl=0
Fertility and abortion: Burmese women's health on the Thai-Burma border
(Belton, Susanne & Maung,Cynthia).
http://www.fmreview.org/text/FMR/19/17.htm
QEH Working Paper Series QEHWPS94, Working Paper 94 "*External Aspects of Self-Determination in Burma".* Sandra Dudley, February 2003
Point Reyes Station doctor aids Burmese refugees
http://ptreyeslight.com
FMR19: Published January 2004
Fertility and abortion: Burmese women's health on the Thai-Burma border Suzanne Belton & Cynthis Maung
http://www.fmreview.org
Public Health Status of Border Communities in the Meking Basin
CRED Background Paper by Saskia Nijohof, December 2003 Center for Research on the Epidemiology of Disasters (CRED)

Refugee Children and Health

Council of State and Territorial Epidemiologist, Position Statement Template, Revised 1/18/05.
Submitting Author:
Gchavez1@dhs.ca.gov
World Health Organization
http://w3whosea.org
Promises Broken: Refugee children, 2006 http://www.hrw.org/campaigns/crp/promises/refugees.html
Academies Press, Child Health in Complex Emergencies (2006) http://www.nap.edu/openbood/0309100631/html/2.html
WHO – Diarrhoeal Diseases-http://www.who.int/vaccine_research/diseases/diarrhoeal/en/print.html
HIV/AIDS and breast-feeding http://www.hawaii.edu/hivandaids/Faq%20on%Breastfeeling%20abd%20HIVAIDS.pdf
World Health Organization
http://www.who.int/children-adolescent-health/Emergencies/CHCE_review.pdf
Pan American World Organization
http://www.paho.org/English/org/CD46-inf2-e.pdf

Other Resources

Toole J, Waldman J. Prevention of excess mortality in refugee and displaced population in developing countries. JAMA 2000; 263;3296-302
Toole, M. Preventing micronutrient deficiency diseases. Workshop on the improvement of the Nutrition of Refugees and Displaced people in Africa.
U.S. State Department, Bureau of East Asian and Pacific Affairs, Country Profile, 2004.
Sembra, R.D. Bloem, M.W. Eds. Nutrition and Health in Developing countries 2001:327-342 Humana Press, Totowa, N.J. The New England Journal of Medicine, Volume 321:1301-1305.
Letter from CDC's Division of Global Migration and Quarantine dated June 23, 2004.

Appendix I

Directory

State Agencies

Dept of Human Services (DHS)
Office of Health and Human Services
Louis Pasteur Building
600 New London Avenue
Cranston, RI 02920
http://www.dhs.state.ri.us/

DHS Child Care Assistance Program
600 New London Avenue
Cranston, RI 02920
http://www.dhs.state.ri.us/dhs/famchild/dcspgm.htm

RI Childhood Lead Poisoning Prevention Program
Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908
http://www.health.ri.gov/lead/index.php

DHS Food Stamp Program
Office of Health and Human Services
Louis Pasteur Building
600 New London Avenue
Cranston, RI 02920
http://www.dhs.state.ri.us/dhs/adults/fsadult.htm

State Service Providers

Family Services of Rhode Island
55 Hope St.
Providence, RI 02906
http://www.familyserviceri.org/default.htm

The RISE Clinic, Miriam Hospital
14 Third St.
Providence, RI 02906
http://www.lifespan.org/Services/Infectious/TB/default.htm

Women's Cancer Screening Program
Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02908
http://www.health.ri.gov/disease/cancer/women-screening.php

National Organizations

CDC Division of Global Migration and Quarantine
1600 Clifton Rd.
Atlanta, GA 30333
http://www.cdc.gov/ncidod/dq

Office of Refugee Resettlement
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447
www.acf.dhhs.gov/programs/orr

Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
www.health.state.mn.us/divs/idepc/refugee/index.html

International Organizations

International Organization for Migration
17 route des Morillons
C.P. 71
CH-1211 Gèneve 19
Switzerland
www.iom.int

Office of Global Health Affairs
5600 Fishers Lane, Room 18-105
Rockville, Maryland 20857
www.globalhealth.gov/oirhrefugeehealth.shtml

UNHCR
United Nations High Commission for Refugees
Case Postale 2500
CH-1211, Gèneve 2 Depot
Suisse
www.unhcr.ch

Cultural Competency Resources

Culturally and Linguistically Appropriate Services (CLAS) Standards
http://www.omhrc.gov/clas/

Ethno Med.
University of Washington
Harborview Medical Center
www.ethnomed.org

National Center for Cultural Competence
Early Childhood Research Institute
University of Illinois at Urbana-Champaign
http://gucchd.georgetown.edu//nccc/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